United States Court of Appeals
for the Second Circuit

EXHIBITS

77-6015

COMMITTEE ON WAYS AND MEANS B
U.S. HOUSE OF REPRESENTATIVES

COMMITTEE STAFF REPORT
ON THE
DISABILITY INSURANCE PROGRAM

JULY 1974

Prepared by the staff of the
COMMITTEE ON WAYS AND MEANS
for the use of the committee

Exhibit A
White v. Mathews # 77-6015

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Preface

In its report on H.R. 11333 in November of last year the Committee expressed concern about the financial soundness of the social security system and instructed both the Social Security Advisory Council and the Committee staff to conduct independent reviews of its actuarial condition and major program aspects. One of the major areas of cost deficiencies in the system has been the Disability Insurance program. Because of this and the substantial impact the new Supplemental Security Income (SSI) program will have on the Disability Insurance program, the Committee staff has prepared this Staff Report on the Disability Insurance program as an integral part of its broader study of the social security program.

The Committee staff would like to express its appreciation for the valuable assistance it received in preparing this report from Mr. Frederick B. Arner, Senior Specialist in Social Security Legislation, attached to the Education and Public Welfare Division of the Congressional Research Service, Library of Congress and his research assistant, Ms. Christi White. Mr. Arner has had a deep interest in the Social Security Disability Insurance program for many years, including service as counsel to the Special Subcommittee on the Administration of the Social Security Laws (Harrison Subcommittee) of the Committee on Ways and Means in 1959–1960. The Congressional Research Service also contracted with Mr. Robert J. Myers, former Chief Actuary of the Social Security Administration and presently Professor of Actuarial Science, Temple University, to provide the Committee with an independent evaluation of the actuarial status of the Disability Insurance program.

In preparing this report the staff has had discussions with personnel at various levels of the Bureau of Disability Insurance, the Office of the Actuary, the Bureau of Hearings and Appeals, and the Office of Research Statistics, Social Security Administration, and the HEW Office of General Counsel. Most of the factual information (particularly the information contained in Part III) was elicited by several series of questions presented by the staff to the Social Security Administration. In addition, the staff has drawn extensively from the following existing studies of the disability program:

1. Administration of Social Security Disability Insurance Program, Preliminary Report to the Committee on Ways and Means submitted by the Subcommittee on the Administration of the Social Security Laws (Harrison Subcommittee Report) and related documents, 1959–1960.
2. Social Security Administration Survey of the Office of Hearings and Appeals, by Covington and Burling (Horsky Report) 1960.
3. "The Social Security Administration: An Inter-Disciplinary Study of Disability Evaluation," by George J. Goldsborough, Jr., William G. Tinsley and Arnold C. Steinberg, prepared under the auspices of the Graduate School of Public Law, the National Law Center of the George Washington University (G.W. report), 1963.
4. "Social Security Disability and Mass Justice—A Problem in Welfare Adjudication," by Robert G. Dixon, Jr. Praeger Publishers, 1973.

Part I presents the staff's summary and recommendations on the basis of its preliminary study of the disability program. Part II contains the staff's more detailed study of a number of the major issues in the Social Security and Supplemental Security Income disability programs. Part III presents statistics and other program information furnished by the Social Security Administration primarily in response to questions submitted by staff. These have been arranged in an appropriate subject area breakdown. The legislative history of the disability program and the informational paper on attorney's fees in Part III were prepared by Ms. Christi White, Technical Information Specialist, Congressional Research Service. Since the materials contained in Part III were furnished at various times, some of the data may not reflect the most recent data available at the time the report was printed.

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Committee Staff Report on the Disability Insurance Program

PART I. SUMMARY FINDINGS AND RECOMMENDATIONS

A. Introduction

Chronic actuarial deficiencies have developed in the Disability Insurance system over the last ten years. At present, social security disability awards are substantially greater than estimated and there is some reason to believe that elements in the new Supplemental Security Income (SSI) program may accelerate this trend. The State Agency-Federal disability determination system seems extremely hard-pressed due in large part to the Social Security Administration's added responsibilities under SSI. The Black Lung program has drained key staff away from social security duties, and is now virtually monopolizing the services of the Social Security Administrative Law Judges.

The multileveled appeals procedure is time-consuming and the high reversal rates suggest to applicants whose claims have been denied the wisdom of continued appeal. Recently, the Social Security Administration has cited the reversal rate as one of the probable reasons for the current adverse cost experience. Each level in the appeals process is experiencing a workload crisis or will experience one in the near future. The effort to achieve uniform application of the standards which determine disability is thwarted by a complex arrangement of relatively separate administrative entities. This tendency may be accelerated by recent efforts to "regionalize" administration of the disability program.

The central office of the Social Security Administration has now reduced what used to be a 100-percent check of State Agency decisions to a national 5-percent sample and a 7-percent sample of SSI cases will be reviewed in regional offices after they are effectuated. An independent Administrative Law Judge, upon a request for a hearing, makes the final administrative determination subject to review by an Appeals Council. Reversal of State agency decisions at the hearing level are above 50 percent and studies indicate that the individual reversal rates of Administrative Law Judges vary markedly.

Final administrative denials are reviewed by the Courts under the substantial evidence rule which states that "the findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive * * *." Despite this, the experience under the program is that many courts continue to review the facts *de novo*. Some have argued that the Courts have played a more substantive role in the development of the definition of disability than the Congress or the Social Security Administration. Others have maintained that the definition in the law is so subjective that it invites a variety of administrative interpretations and judicial intervention.

These are a few of the issues dealt with in this volume.

Robert G. Dixon, Jr., summarized his study of the Social Security Disability Insurance program in the following manner:

> All studies of the administrative process tend to emphasize trouble spots and thus to give a somewhat distorted impression of the program's efficacy in discharging its frequently confused statutory mission. This study is no exception. At the same time, the data gathered here on the SSA disability standards and procedures does seem to suggest that the government, and the American people, have a tiger by the tail and that it is easier to identify difficulties than to prescribe solutions. This should come as no surprise. As one high

former HEW official remarked in reference to this study, disability is historically the most difficult kind of welfare or "social insurance"; standards are elusive and individual equity is difficult to accomplish.[1]

The Committee staff's review of the Disability Insurance program also is no exception. It, too, emphasizes trouble spots and thus may tend to give a distorted impression of the program's efficacy. The staff does not conclude, however, that the Disability Insurance program faces imminent catastrophe. The information compiled in this report indicates clearly that a number of serious problems exist in connection with the operation of the program. Some of these problems, it is hoped, are temporary, particularly those resulting from the strains that the Social Security system has undergone in connection with the implementation of the Supplemental Security Income program and the carrying out of the Social Security Administration's responsibilities under the Black Lung Program. Other problems arise out of the manner in which the program is being administered and out of the law itself. These problems, however, are not beyond the capabilities of the Social Security Administration or the Congress and they can be corrected or at least held within reasonable bounds by assuring that this admittedly complex program is administered efficiently at every level.

B. Capsule Description of Social Security and SSI Disability Programs[2]

CASH BENEFITS

The Disability Insurance program, providing cash benefits to disabled workers over age 50 was established by Congress in 1956. Dependents' benefits were added in 1958 and the age 50 requirement was eliminated in 1960. To qualify for benefits an individual must meet certain coverage requirements, which have been modified over the years, but still require that workers disabled after age 31 must have worked 5 out of the last 10 years prior to their disability. For younger workers progressively fewer years of coverage are required but the minimum is a year and a half.

The definition of disability originally required that the worker must be unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration." In 1965 the test was reduced from "long-continued and indefinite duration" to the present 12 months' duration test. Originally a worker was required to be disabled 6 full calendar months before the first month for which benefits were payable, but the waiting period was reduced to 5 months by the Social Security Amendments of 1972.

The 1972 amendments also "federalized" the State public assistance programs for the needy aged, blind, and disabled into the new Supplemental Security Income (SSI) program, which pays Federal benefits, under uniform rules, financed from general revenues. Payments under the SSI program, which started in January of 1974, may be supplemented by the individual States. Under SSI, disabled persons on the State programs 1 month before July 1973 were automatically "grandfathered in" but new applicants and applicants who came on the welfare rolls after June 1973 will have to meet the social security definition of disability (and new applicants will have to meet the Federal income and assets requirements).

FINANCING

In order to closely monitor the costs of the disability program Congress established a separate Disability Insurance Trust Fund into which a specified percentage of social security payroll tax receipts are deposited and from which all disability insurance benefit payments and associated administrative costs are disbursed.

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[1] Robert G. Dixon, Jr., "Social Security and Mass Justice—A Problem in Welfare Adjudication," Praeger Publishers, 1973, p. 130.

[2] Only the major features and their development are outlined here. A more detailed description of the program and its legislative history is contained in part III, pp. 107-124.

VOCATIONAL REHABILITATION

Provision has been made for the referral of disabled worker beneficiaries to vocational rehabilitation since the start of the program. A specified percentage of the Disability Insurance Trust Fund may be utilized to pay for the expenses involved in the rehabilitation of individuals receiving disability benefits. Similar financing of services for SSI beneficiaries is authorized out of general revenues.

ADMINISTRATIVE MECHANISM

Because it was concerned with the problem of rehabilitation and relationships with the medical profession, the Congress indicated that it wanted the actual determination of disability under the Disability Insurance program to be carried out by the State vocational rehabilitation agencies. Thus, the law gave the Secretary of Health, Education, and Welfare the authority to contract with the State vocational rehabilitation agency, or another agency the State might designate, to carry out the function of determining disability under the Federal program. This same system has been carried over into the SSI program.

In the administrative process the State disability determination units are sandwiched between other Federal components which administer the disability insurance program. Social security district office personnel carry out the initial interviewing of the applicant and determination of insured status. After the State agency has made the initial determination of disability, its decision is subject to review by the Bureau of Disability Insurance. Until recently, all initial determinations by the State agencies were reviewed in this manner, but beginning in 1972 such review has been limited to a 5-percent national sample. In addition, a denied claimant may (1) request reconsideration by the State agency, (2) if denied, request a hearing before a Federal Administrative Law Judge, and (3) if again denied, request review by the Appeals Council. After these administrative remedies have been exhausted, an appeal may be taken to the Federal court system.

SCOPE OF THE PROGRAM AND CURRENT WORKLOAD

Since the Committee's last major study of the Disability Insurance program in 1960 (by the Harrison Subcommittee), the number of beneficiaries on the rolls of the program has grown from 750,000 disabled workers and dependents to about 3.5 million workers and dependents. In 1960 the State agencies were conducting about 30,000 disability determinations a month. In June of this year the State agencies were making social security and SSI determinations at a rate of over 60,000 a week. The total number of cases pending—both social security and SSI—is now about 400,000 in the State agencies. This does not take into account just under 200,000 cases in the district offices. At this stage, receipts of Social Security and SSI cases are in approximate equilibrium with dispositions, and recently there has been a slight reduction in the backlog of cases. In some States, however, this backlog is quite serious and Federal personnel have been assigned to a number of State agencies. Concurrent with this have been delays and interruptions in benefit payments and breakdowns in handling priority correspondence.

In the fall of 1973 it was estimated that during fiscal 1974 there would be 1.6 million determinations of disability for the Social Security program and 800,000 SSI determinations. By the end of May there had been 1,000,000 regular Social Security determinations for the fiscal year and 450,000 for SSI.

The workload in the hearings and appeals area shows a different configuration since few SSI cases are presently that far advanced. Social Security Administrative Law Judges as a group have been used to augment the relatively few Black Lung Administrative Law Judges to deal with a caseload which now numbers 35,000 for Black Lung alone. This caseload has been particularly difficult to deal with because of its wild gyrations. Early in 1972 it totaled almost 40,000 Black Lung cases but it was virtually eliminated when 30,000 cases were remanded from the hearing stage for redetermination by the Bureau of Disability Insurance. After the massive redetermination of these cases by BDI, however, over 40,000 requests for hearings have been received by the

Bureau of Hearings and Appeals in 1974. This means the ALJ's will get increasingly behind in regular Social Security cases and be in a real crisis when the full impact of the SSI appeals is felt. No SSI hearings examiner has yet been hired. Finally, the number of cases pending in Federal courts has reached record highs, and the ability to effectively litigate these cases appears to be getting increasingly marginal. This situation will become much more serious, particularly in District Courts in the Appalachia region, when the bulk of the Black Lung cases pass the administrative review stage. A similar phenomenon will occur later in SSI. Within 2 or 3 years, District Court case filings in the disability programs may rise to the neighborhood of 10,000 cases a year. The number of filings in fiscal 1973 were approximately 2,000 cases.

C. Findings and Recommendations

1. Actuarial Deficiency in Disability Program

In the last 5 years the estimates of the cost of Disability Insurance system have almost doubled. The 1973 Trustees' report (H. Doc. 93-130) and the 1974 Trustees' report released on May 31, 1974, state that the Social Security Administration has launched a major study to find out the reasons for the unanticipated adverse experience in the system. All indications are that this study is proceeding exceedingly slowly.

In the past, actuarial deficiencies have been eliminated by increased allocation of payroll tax receipts to the Disability Insurance system. Higher allocations were effectuated in 1965, 1967, and, to a smaller degree, in the two social security bills which were enacted in 1972. The last such action was taken in Public Law 93-233 which was approved on December 31, 1973. The 1974 Trustees' report suggests reallocation of income among the three trust funds (OASI, DI, and HI) as a possible solution to the short-range financing problems of the Social Security program. The staff recommends that no further action of this nature be taken—which, to some degree, avoids facing the problems in the Disability Insurance program—until the Committee receives an adequate explanation of the adverse experience which is taking place in the system.

The long-range actuarial deficit of nearly 3 percent of payroll in the Social Security program announced in the Trustees' report is a clear indication that the practice of increasing the allocation of funds to the Disability Insurance Trust Fund cannot be indulged in in the future as it has been in the past. Prior to 1972 there was a built-in "safety" factor in the "level earnings" assumption that was used in estimating the long-range cost of the social security program. The use of the level earnings assumption generated actuarial surpluses as earnings levels rose and they had been used, among other things, to make up for adverse disability experience. However, under the "dynamic earnings" assumption adopted in 1972 this cushion no longer exists.

(For further discussion of this general topic, see part II, section A, Increased Cost of the Disability Insurance Program, pp. 13-16.)

2. Study of Federalization of State Disability Determination Mechanism

Contemporaneous with the Harrison Subcommittee study in 1959, the General Accounting Office stated that its "review indicated that the handling of applications for disability benefits by the State agencies is cumbersome and results in unnecessary costs and excessive processing time." It recommended that the Secretary of HEW "determine whether the benefits derived from the states' participation in the disability insurance program are commensurate with the costs" and that the Secretary should "review and evaluate the present Federal-State arrangement to determine the best arrangement for making disability determinations and that he report thereon to the appropriate legislative committees of the Congress." The staff notes that the Committee has not yet received a report on these matters and that many of the deficiencies noted in the GAO study still appear to exist. The staff believes that this is a particularly appropriate time (1) for the GAO to review its finding on the State agency operation, and (2) the Secretary of HEW to report to the Committee on Ways and Means whether any structural changes are required.

(For a full discussion of the issue of the State Agency role in determining disability see part II, section B, State Agency Operation: Federal-State Structure, pp. 17–26.)

3. SOCIAL SECURITY APPEALS PROCEDURE

There is a substantial question as to whether the multitiered Social Security appeals procedure can withstand the current workloads under Social Security and SSI, even if the present Black Lung situation is only a temporary aberration.

At the administrative level 40,000 Black Lung hearings were supposed to be disposed of in the last half of fiscal year 1974. This is being done on a crash basis while regular Social Security hearings accumulate. SSI hearings will commence later in the calendar year and will constitute a large workload of still undetermined dimensions. The median processing times for regular DI claims, before the impact of SSI and Black Lung is felt, raise substantial questions in themselves—75 days for initial determinations, 64 days where the denial of benefits is upheld on reconsideration, and 163 days for the hearing.

A Harrison Subcommittee admonition in 1960 seems still pertinent today. It stated, in answer to the Department's assertion that the many reviews and re-reviews of decisions were necessary to assure uniformity in the operation of a nationwide program, that the "question of whether a claimant becomes exhausted in the process of exhausting his administrative remedies is always a real one."

Exhausting legal remedies in the courts can be exhausting too. Today there are about 4,700 Social Security cases pending before U.S. District Courts, about 4,200 of which are disability cases. Moreover, legal personnel shortages in the HEW Office of the General Counsel have caused further delays in litigation. The median time for social security law cases disposed by District Courts in fiscal 1973 was 10 months. Ten percent were settled in less than 3 months but ten percent required 30 months or more. With the great acceleration of court filings this situation can only get worse.

There are indications that the significant differences [3] in results between the different levels in the review system—the State agencies, the Bureau of Hearings and Appeals, and the Judiciary—may be linked to subtle differences in the standards for determining disability and, perhaps more importantly, the methods of applying the standards. There is a breadth of variation at each level of review which causes concern as to whether equal justice is being provided under the system. Commentators on the program have pointed out that perseverance in pushing an appeal may be the most important ingredient in success in the borderline cases and that Supreme Court Justice Blackmun's statement in the *Perales* case that a 44.2-percent hearing examiner reversal rate attests to "the fairness of the system" does not fully reflect the unevenness that exists in the system.

In view of the "appeals crisis" which will grow in coming months, the Committee may wish to reexamine the complex structure of the appeals procedures and attempt to obtain answers to the following difficult questions: Can the Appeals Council be restructured in order to provide more definitive and supportable administrative determinations? Can the system continue to provide both a full administrative reconsideration and a hearing under the Administrative Procedure Act (APA)? Are certain of the administrative and judicial remand procedures causing undue delay for claimants? Can the District Courts withstand the flood of new cases, particularly where many of them ignore the substantial evidence rule and try the case de novo? The staff has, in a preliminary manner, examined some alternative approaches to these problems and they are presented in Part II, section D, Disability Appeals Procedure, in this document (pp. 31–44).

The Civil Service Commission has interpreted the 1972 Amendments in such a manner as to exclude SSI hearings from the applicability of the APA and has decreed that the SSI "hearing examiners" must be appointed by the

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[3] State denial rates vary between 34 percent and 60 percent; ALJ's reversal rates vary between 30 percent and 90 percent. Similar variations exist with respect to decisions of the district courts.

Secretary of HEW rather than by the Commission and classified at a lower grade than those who conduct Social Security disability hearings. The Commission's conclusion with respect to the applicability of the APA to SSI hearings is clearly contrary to the intent of the Committee and the Congress. In Part II, section F, Status of the SSI Program Under the Administrative Procedure Act (pp. 55–75), the staff makes certain recommendations in this area which are intended to make clear the Committee's intent concerning the SSI hearings procedures.

4. Examination of the Definition of Disability

The basic definition of disability is virtually the same today as was recommended by the Advisory Council on Social Security to the Senate Finance Committee in 1949. The original idea was that the broad language of the statutory definition would be amplified by regulations based on operational experience. As it has turned out the Courts, rather than the Social Security Administration or the Congress, have effectuated the major changes in the definition, particularly in the area of the definition's somewhat subjective nonmedical factors. Some commentators believe that the definition of disability is so subjective that widely varying interpretations at different levels of administrative review, or even at the same level, should be expected. The highly individualized determinations of disability prompted one District Judge to state that "to particularize that a certain human being with individualistic impairment and limitation may or may not have employment opportunity in a certain area, in my inexperienced judgment, may require an elite group of soothsayers superbly trained to probe the many intangibles." (*Stoliaroff* v. *Ribicoff* (1961) 198 F. Supp. 587, 591). Dixon writes that "neither the initial congressional definition of disability nor the re-definition of 1967 seems to be administratively manageable if the courts ignore the substantial evidence rule". (p. 51)

Others see social value in the individualized determination and the elaborate appeals system, particularly in view of Social Security's "all or nothing" aspects as compared with the flexibility that exists in the VA disability and workmen's compensation programs which allow for various degrees of disability.

The staff believes that the Department of HEW with the assistance of skilled personnel from the State Agencies and those in the private sector with expertise in disability adjudication should explore the possibilities as to whether the definition of disability can be stated more specifically in the law or regulation, and whether more operational presumptions may be incorporated into its administration so that the definition can be more effectively applied to greatly accelerating caseloads. Both the mechanism for developing precedent materials and the material itself seem poor and should be improved. Such a task force should also reexamine the definition of disability in the context of a growing adverse cost experience and how it may apply to disability benefits provided under the new SSI program.

The SSI population has, to a high degree, the characteristics of the borderline cases which have been so difficult to adjudicate under the Social Security definition. SSI applicants, based on the experience of the old public assistance disability program, will have less work experience and education, and will have more mental, alcoholic, and drug addiction problems than Social Security disability applicants. There will also be a higher proportion of women applicants than under the Disability Insurance program who will present problems because of their limited work histories. Moreover, under SSI there is no waiting period required before benefit eligibility, and the applicants are generally in worse financial shape and more likely to need speedier adjudication of their claims. Thus, the appropriateness and administrability of the Social Security definition for SSI should be watched closely. Strict application of the Social Security definition may leave a substantial group of people to State and local resources. On the other hand, more flexible administration may create precedents which could well flow over into the Social Security disability program with very substantial effects on that program and its cost.

The Social Security Advisory Council which reported in 1971 suggested an amendment to the law in the nature of an occupational definition for older workers and elimination of the 12-month duration requirement. The cost estimate it gave for this change was less than one-half of the cost of the subsequent adverse experience which was reported to the Congress in the years that followed. Therefore, the staff believes that sounder information is needed on the ramifications of the current definition before major policy decisions are made in this area. If the current Advisory Council does make legislative recommendations in addition to studying the actuarial condition of the program, an examination of the definition of disability would appear essential.

A more detailed discussion of the definition of disability is contained in Part II, section E, Standards and Definition of Disability (pp. 45–54).

5. FEDERAL REVIEW OF STATE AGENCY DECISIONS

Under the law, the Secretary has the authority only to reverse State agency allowances of disability under the DI program or to make the onset date of disability a more recent date. He does not have the authority to reverse State agency denials.[4]

The conference report on the original cash disability program in 1956 stated that "it is understood and expected that the Secretary of Health, Education, and Welfare will fully utilize his authority to review and revise determinations of State agencies in order to assure uniform administration of the disability benefits and to protect the Federal Disability Insurance Trust Fund from unwarranted costs" (H. Rept. No. 2936, 84th Cong., 2d sess., p. 26).

Although there may be valid arguments for such action, the Social Security Administration recently has taken administrative steps which are tantamount to amendment of the statutory scheme of the Disability Insurance program. It has moved from a 100-percent review and ability to reverse all State allowances to review and possibly act on only a 5-percent sample of State cases.

When the sample approach was adopted in mid-1972 between 6 and 7 percent of allowances were being questioned by the Social Security Administration, but this increased to a 28 percent average in calendar 1973. Although the Social Security Administration states that these figures are the result of more intense review of the sample cases (done primarily by medical staff in Baltimore) and reflect more technical flaws than substantive adjudicative errors, these statistics indicate an alarming number of deficiencies in development of allowances cases and the distinct possibility that a rather large number of individuals are coming on the rolls who may not meet the standards of the law.

The Social Security Administration is also establishing a system of sample review in SSI disability cases by separate units in the 10 regional offices. Moreover, the Social Security Administration has taken the position that it has authority to reverse State agency denials of SSI claims, as well as allowances. The staff believes that the Congress intended that disability determinations under SSI are to be conducted by the State Agencies in exactly the same way as they are under social security.

With social security disability allowances occurring at rates which are threatening the actuarial soundness of the system, these administrative decisions which affect the basic legislative structure of the program should be reexamined.

For a fuller discussion of this general topic, see Part II, section C, Review of State Determinations of Disability (pp. 27–30).

6. REGIONALIZATION AND BUREAUCRATIZATION: AN ADDED DIMENSION

The social security disability program has always been the most complex of the Federal cash benefit programs to administer. The unique State agency operation and relatively autonomous Federal entities in the appeals procedure have already been mentioned. However, there have been some recent developments which are at some variance with traditional social security administrative patterns. First, there is a growing regionalization of the disability program, for reasons that are difficult to specify. This could be the result of the Administration's general program of decentralization of Federal programs; the growth of the Disability Insurance and Black Lung programs; the advent of SSI; or a combination of these. Within the year mini-organizations similar in structure to the Bureau of Disability Insurance in Baltimore have been created in the 10 regional offices throughout the United States to review State Agency determinations in SSI cases and the regional offices are playing a major and growing role in guiding and supervising the disability program.

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[4] In 1959–1960 the Social Security Administration requested legislative authority to reverse State Agency denials of disability. The Committee and the Congress did not acquiesce in this request.

Along with these developments there seems to be a tendency to proliferate administrative units which report to the ultimate policymakers in social security headquarters. For instance, review and appraisal of the State agency operation appear to be assigned in one degree or another to four of the five major units in the Bureau of Disability Insurance. (Strangely enough, the fifth unit, which is specifically charged with policy formulation, seems somewhat out of the flow in getting reports on the substantive problems of the system.) This dispersion of responsibility means that the Bureau Director will be getting reports from the four separate units and 10 regional directors. Moreover, outside the Bureau of Disability Insurance, there are other separate Social Security Administration entities which have responsibilities in the disability program: The Office of Program Evaluation and Planning, the Office of Research and Statistics, and the Office of the Actuary. Coordination is also highly important between BDI (and the State Agencies) and the Bureau of District Office Operations and its regional organization. The Bureau of Supplemental Security Income has a somewhat amorphous role in regard to the blind and disabled under SSI.

There has also been a proliferation of "quality control" units at all levels in the system. The very existence of these units seems to have a "Linus' security blanket" effect on the administrators. Whether they are contributing in a significant way to the uniform administration of the program or instead to the further bureaucratization of the system remains to be seen. Because the staff has not been able to review this area as thoroughly as it feels is warranted, the Committee may wish the GAO to examine the current administrative direction of BDI in carrying out a uniform Federal program, with particular reference to the plans for regionalization of the system.

7. IMPACT OF BLACK LUNG PROGRAM

The Committee staff believes firmly that the Black Lung program has had a major impact on the Social Security program in diverting essential administrative and program staff from their duties with regard to the Social Security Disability Insurance program and the implementation of the SSI program. This had been particularly true of the policy and review staff of the Bureau of Disability Insurance, who overnight had to develop regulations and operating procedures for a broadly and loosely phrased piece of legislation and to immediately start processing and deciding cases. The agency was faced with an instant caseload when about 100,000 claims were filed within 1 month of enactment.

The Black Lung program came out of 1969 legislation in which neither the House nor Senate versions contained a provision for the Social Security Administration to administer the program. The decision to give the Social Security Administration responsibility for administering the initial phase of the program was made by the conference committee in December 1969. Prelegislation planning for the implementation of Black Lung programs was nonexistent and its impact on the social security disability program was completely unassessed. It is unfortunate that the Committee on Ways and Means was not consulted or even informed at the time action was taken by the conference committee in December 1969.

At the present time, the Black Lung crisis has moved to the hearing stage where Social Security disability cases are being literally shunted aside so that the flood of Black Lung cases can be dealt with. The courts and the Social Security litigation staffs, who are already hard pressed, will soon be similarly adversely affected and their ability to carry out their Social Security disability duties will be further impaired. (Social Security responsibility will continue for Black Lung beneficiaries who applied prior to July 1, 1973, and the Social Security District Offices will continue to take applications for the Labor Department-administered Black Lung program until that program expires in 1981.)

The staff is concerned that any further enlargement of Social Security responsibilities may be "the straw that breaks the camel's back." To avoid repetition of the establishment of programs through other Committees which drastically affect the operation of the Social Security program, the Department of Health, Education, and Welfare should keep the Committee better informed of such possible developments and alternative courses of action. The staff notes that the House Committee on Education and Labor has recently conducted hearings on legislation for the extension of the Social Security Black Lung program for two additional years.

The staff also notes that the Special Committee on Committees overlooked the black lung legislation in making its recent recommendations for joint referral of legislation to more than one committee.

8. EARNINGS LIMIT FOR DISABILITY BENEFITS

An example of a policy issue that has not been dealt with because of the diversionary effect of the Black Lung program and other workload crises is the amount of earnings an individual can have and still retain disability benefits. Initially this had been linked to the "retirement test"—the limit on earnings after which social security old-age and survivor's benefits will be reduced. Although Congress in recent years has changed the retirement test exempt amount from $140 a month to $166 a month, and, finally, to the current $200 a month, the earnings limit on disability has remained at the level established in 1968—$140 a month. (There is also a 9 month trial work period during which all earnings above this figure are disregarded in order to stimulate work effort.) The current figure would appear to constitute a major inhibiting factor to work and rehabilitation. Moreover, this work disincentive feature has been intensified by the major social security benefit increases in recent years. In 1968 allowable earnings of $140 a month were not too far out of line with the average benefits of about $180 a month for a disabled worker with a wife and one child. Today that same family would be receiving benefits of about $300 a month and the cutting off of those substantial benefits when the $140 a month earning level is attained can hardly be encouraging to work efforts. Under SSI a similar situation can occur whereby an individual can be getting a substantial income disregard under an approved plan for self-support, but once he goes over the $140 a month limit his benefits will be totally eliminated. The staff understands that various alternatives have been presented to the Secretary of HEW for raising the $140 limit, but no final action has been taken to change the regulations concerning this matter.

9. PRIVATE DISABILITY INSURANCE AND SOCIAL SECURITY

In the last 15 years there has been a substantial growth in private disability insurance contracts and disability retirement provisions in private pension plans. The Social Security Administration informs us that it believes that about 20 million people have disability protection through their pension plans and that group long-term disability policies cover about 8.6 million people. Although some workers have protection under both types of coverage, it is estimated that roughly 25 million wage and salary workers, or about two-fifths of the wage and salary labor force, have protection against the risk of long-term disability through non-government arrangements which supplement Social Security disability benefits.

The Congress is getting an increasing number of communications from social security disability beneficiaries complaining that the recent benefits increases have not increased their income because in many cases their private disability benefits have been correspondingly reduced.

As to private pension plans which are eligible for IRS tax advantages, current regulations provide that payments under an integrated pension plan cannot be offset by more than a given percentage of the Social Security disability benefit. Moreover, since 1972, any additional dollar increases in Social Security benefits cannot further reduce the pension plan disability benefit after a person qualifies for a Social Security disability benefit. The current regulations are ratified by the House-passed legislation on pension plan reform (H.R. 2) but at present it is not clear from the legislative history that the prohibition against reduction is intended to apply to Social Security disability as well as retirement benefits. The staff suggests that the scope of this provision be clarified by a statement in the Conference report. The Committee report on the pension plan legislation (H. Rept. 93–779) questions the validity of the Social Security offset provision in general, but recommended that legislative action be deferred pending a study. This will be pursued by the staff.

Straight disability insurance contracts, on an individual or group basis, present a more difficult problem since their regulation has traditionally been left to the States. Most of these disability plans contain Social Security offset provisions and the substantial increases in benefits in recent years must have made major reductions in costs to insurers. Whether this has meant greater profits to the insurance companies, a reduction in premium charges, or an increase in dividend payments to policyholders is not clear. The staff will explore these questions with the insurance industry, the State Insurance Commissioners, and interested consumer agencies and groups.

10. REHABILITATION

The structure of the Disability Insurance program has been based on the proposition that appropriate disabled persons should be referred to vocational rehabilitation with the expectation that a sizeable number of them would be returned to the labor force. In 1960 the Harrison Subcommittee noted the few rehabilitations that had taken place and was particularly unhappy "with the lack of uniform and comprehensive statistics in the rehabilitation area". It recommended "that the Secretary of Health, Education, and Welfare explore means of deriving more meaningful and more uniform data covering this aspect of the program so that Congress and the American people can be given a better picture of the impact of rehabilitation on the disability program".

This appears to have fallen on deaf ears. In response to a question by the staff this year as to the total number of rehabilitants terminated from the rolls for the years 1960 through 1966, the Social Security Administration responded:

> After extensive search, we have been unable to locate the source material for years 1960–1966 necessary to identify beneficiaries who were rehabilitated and the number of rehabilitants who were terminated from the rolls. No provision was made for accumulating and storing these data records prior to the inauguration of the Beneficiary Rehabilitation Program.

In the 1965 Amendments, Congress provided that moneys could be expended from the Trust Funds for the rehabilitation of disabled beneficiaries.[5] To date, in terms of number of rehabilitants terminated from the rolls, this program has not been particularly impressive although the Department of HEW claims overall cost savings to the Disability Insurance system. Only about 14,500 disabled workers, disabled children and disabled widows who have been rehabilitated under the 1965 provision and its subsequent liberalizations have actually left the benefit rolls. Such terminations, moreover, have leveled off in recent years even though in those years substantially more money has been expended from the Disability Insurance Trust Fund for this purpose. It should also be noted that trust fund rehabilitants numbered only 2,408 out of a total of 42,961 terminations by recovery status in 1972. Another related cause for concern is the decreasing number of terminations as a total of benefits in force which has adverse ramifications for the actuarial status of the Disability Insurance system.

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[5] An authorization from general revenues for a similar purpose was contained in the 1972 Social Security Amendments establishing the Supplemental Security Income program.

The Chairman has requested that the GAO study and report back to the Committee on the beneficiary rehabilitation program with answers to the following questions:

(1) How do the Social Security Administration and the Rehabilitation Services Administration coordinate the operation and management of the beneficiary rehabilitation program?

(2) Are the criteria used to select clients for referral under the basic vocational rehabilitation program and the criteria used in selecting clients for services financed by Social Security trust funds services reasonable and consistent?

(3) The rehabilitation agencies emphasize "rehabilitations" in their statistical reporting, whereas the beneficiary rehabilitation program has as a primary goal the "recovery" of individuals in order that they can return to competitive employment. Are these program goals consistent and does the vocational rehabilitation program assist the clients to and through the recovery stage?

(4) Are clients who are accepted for vocational rehabilitation services, which are financed from the disability insurance trust funds those clients who would probably have recovered within a short time without these services?

(5) Do State vocational rehabilitation agencies adequately distinguish between the beneficiary rehabilitation program and the basic vocational rehabilitation program, which is financed out of general revenues?

PART II.—GENERAL DISCUSSION OF ISSUES

A. INCREASED COST OF THE DISABILITY INSURANCE PROGRAM

The estimated actuarial cost of the Disability Insurance program has doubled in about 5 years. This increase is the result primarily of higher allowance (or incidence) rates and lower termination rates. While part of these changes are attributable to changes in the law enacted by Congress during this period, other factors must be looked to in order to account for such significant cost increases. These other factors relate to the manner in which the Disability Insurance program is administered and general economic forces.

The Congressional Research Service has contracted with Robert J. Myers, former Chief Actuary of the Social Security Administration, and now Professor of Actuarial Science, Temple University, to render an independent appraisal of the actuarial condition of the Disability Insurance system, and he will submit a report to the Committee later this year.

From December 1957 through December 1969, the number of disabled workers on the benefit rolls increased gradually, from 150,000 to 1,394,000. Since then there has been a much more rapid growth in the rolls.

Disabled workers in current pay status—December 1970–73

Total	*Increase over previous year*
1970—1,493,000	99, 000
1971—1,648,000	155, 000
1972—1,824,000	176, 000
1973—2,017,000	193, 000

At this stage, the Department is unable to explain the reasons for this adverse experience. In the first public acknowledgement of the situation in the 1973 Trustees Report sent to the Congress on July 16, 1973, it was stated:

> As compared with the long-range cost estimates prepared at the time that the 1971 Social Security Amendments were under consideration, the present estimates show a higher cost. The higher cost is attributed mostly to the disability insurance portion of the system. In the last two years the disability rates—that is, the number of allowed claims as a percentage of the insured population—has shown an increase over previous experience. If the higher rates continue, there will be an increase in costs in later years sufficient to require additional financing. Although it is not yet possible to have a firm judgment on whether or not the increase will be permanent, the actuaries are of the opinion that a significant portion of the increase in the rates may not be temporary and that the possibility of higher costs in the long run should now be recognized in the long-range planning of the program. The Trustees agree and have, therefore, shown the cash benefit program to be out of balance for the long run. However, since much more needs to be known about the change in disability rates before a solid opinion can be made concerning the certainty of higher costs for the later years, the Trustees are not, at this time, recommending an actual change in the contribution rates.
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> The Social Security Administration has set up a comprehensive study to look into the recent increases in disability rates and the study should be expedited. The additional knowledge that will be gained through this study will be of assistance in the determination of any reallocation or other revision of the contribution schedule for the future.[1]

It should also be noted that in the "Statement of Assumptions, Methodology, and Details of the Long-Range Cost Estimates" in the Appendix of the 1973 Trustees Report, the following statement appears:

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[1] House Doc. 93–130, pp. 31–32.

> The assumed incidence rates were based on the estimated actual experience in calendar year 1965, adjusted to reflect some of the recent increases in awarded disability benefits. Since these increases are not yet fully understood, it was not possible to determine what portion of them will turn out to be permanent in nature. It was decided, under the circumstances, that for long-range purposes, the projected cost should reflect about two-thirds of the increases in awards that have already been experienced through the end of calendar year 1972. If in the future the number of awards should continue to increase rapidly, it may be necessary to further revise upward the projections of disabled beneficiaries. On the other hand, it might not be necessary to revise the projection or it might even be possible to revise them downwards if a significant portion of the recent increases turn out to be of a temporary nature.
>
> The mortality and recovery rates are based on the actual experience of the system for the period 1957–67. These experience rates were not modified to take into account any later data. It is possible that the recent increase in the awards may affect the rate at which benefits are terminated, but this will not be known for several years.[2]

The 1974 Trustees Report (H. Doc. 93–313), which was due on April 1, 1974, but was submitted to Congress on May 31, 1974, shows that the assumptions as to incidence rates have been updated to the 1973 experience but the mortality and recovery rates are still based on old data—the 1957–67 experience. The report states:

> The assumed incidence rates were based on the estimated actual experience in calendar year 1965, adjusted to reflect both the increases in awarded disability benefits through the end of calendar year 1973 as well as relevant legislated changes through that year. Although the reasons for these increases are not yet fully understood, it was decided that the projected costs should reflect the total increases that have already been experienced through the end of calendar year 1973. However, although the incidence rates have been increasing steadily for the past several years, no increases beyond the 1973 level were projected. If the incidence rates should continue to increase either in line with the current trend or as a result of the implementation of the disability provisions of the Supplementary Security Income Program, enacted in 1972 and implemented in January of this year, it will be necessary to further increase the projections of the disabled beneficiaries.
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> * * * * * * *
>
> The mortality and recovery rates are based on the actual experience of the system for the period 1957–67. These experience rates were not modified to take into account any later data. It is possible that the recent increase in the awards may affect the rate at which benefits are terminated, but this will not be known for several years (p. 41).

The bulk of the latest increase in cost (0.21 percent of taxable payroll) is due to the change in the assumed rates at which the insured workers become disabled. The remainder of the increase in cost is due to changes in economic and demographic assumptions.

When the 1972 Amendments were enacted on October 30, 1972, the cash-benefits portion of the Social Security system was said to be in exact actuarial balance—with the disability benefits having an estimated long-range cost of 1.31 percent of taxable payroll, on an average yearly basis.[3] By the time of the release of the 1973 Trustees Report (July 16, 1973) the estimated cost of the Disability Insurance benefits had risen to *1.54 percent of payroll*, resulting in an actuarial deficit of 0.23 percent of payroll. When Public Law 93–233 (providing for a two-step 11 percent benefit increase in 1974) was enacted on December 31, 1973, the long-range cost of the disability program was estimated to be *1.58 percent of payroll.* That legislation included a revised tax allocation, which reduced the actuarial deficit in the disability program from 0.28 percent to 0.08 percent of payroll. The latest cost estimate in the 1974 Trustees Report shows a long-range cost of *1.92 percent of payroll* and brings the deficit to 0.40 percent of payroll.

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[2] Ibid. p. 38.

[3] "Actuarial Cost Estimates for the Old-Age, Survivors, Disability, Hospital, and Supplementary Medical Insurance Systems as Modified by P.L. 92–603," Committee on Ways and Means, March 2, 1973, p. 7.

Since the 1969 estimate of the long-range cost of the 1967 Act, the estimated cost of the Disability Insurance system has increased from 0.96 percent of payroll to slightly less than 2 percent of payroll. Approximately one-half of this increase in cost (about 0.5 percent of payroll) is due to higher allowance rates and lower recovery rates being used in the actuarial cost estimates (such changed rates being based, at least in part, on recent experience).

In Part III (p. 334) the Deputy Chief Actuary of the Social Security Administration outlines the basic assumptions used in making the long-range actuarial cost estimates for the Disability Insurance program and gives an analysis of disability awards experience as compared with what was expected. He states that, after appropriate adjustments "for age and sex differences, as well as for the increasing numbers of insured workers, the average disability award rate in 1973 was about 50 percent higher than in 1965." Moreover, the table that accompanies the material shows relatively minor increases in relative disability incidence rates through 1970, but then increases averaging about 10 percent a year thereafter in 1971–73.

The reasons for this adverse experience are not clear. One of the first questions submitted as part of the staff study in December 1973 requested "any preliminary report or information on the Social Security Administration's study of the recent increases in disability rates." The answer which arrived several months later from the Social Security Administration stated "our opinions on the reasons for the increase in awards are substantially the same now as when we first started studying this problem." The answer went on to state:

> Preliminary analysis appears to indicate that there is positive relationship between the unemployment rate and the number of applications filed for disability insurance, and that the number of awards is a function of the amount of applications received.[4] Since * * * economic conditions in the United States at the present time will probably lead to an increase in the unemployment rate, we might expect the number of awards in the near future to further increase. Economic models taking this economic and other factors into consideration will be included in a later report.
>
> In addition to the unemployment rate, changes in the number of reconsideration and hearing allowances also have contributed to the increase in awards. The number of disability awards in a given year are essentially the sum of initial allowances, reconsideration allowances, and reversals of prior denials at the hearing level. The data supplied by BDI show that *initial allowance rates have decreased* since 1969, and are at present about 43.8 percent. However, receipts increased considerably after 1970. This increase in applications, even though the allowance rate has not increased, causes an increase in the number of initial allowances. Reconsideration allowances, however, have increased considerably in the past few years, from 32,000 in 1970 to 62,000 in 1973. Likewise, allowances at the hearing level in the 70's were quite a bit higher than in the 60's, e.g., 24,000 allowances in 1973 vs. 10,000 in 1969. While this higher rate of increases in the appeals process does not, of course, completely explain the total increases experienced in recent years, we feel that these increases do contribute substantially to the total increase.

The Social Security Administration stated that the study of the most recent data on the relationship of unemployment and the appeals process to the incidence is "nearing completion." This was in March 1974; on May 10, 1974, the staff was told that this study is still not complete, but will be included in the 1974 Trustees Report. The Trustees Report released on May 31, however, states:

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[4] Staff note: A table showing the number of applications for disability benefits 1962–74 is included in part III, page 344, together with a table showing the rates of insured unemployment for a similar period.

> A more complete knowledge of possible future trends in the number of disabled worker beneficiaries will not be available until the current study of the recent increases is completed (p. 7[illegible]).

The Social Security Administration also believes that increased public awareness, heightened by publicity about the Supplemental Security Income program, has contributed to increases in disability applications and awards.

As indicated earlier, the current cost estimates for the Disability Insurance program are based on mortality and recovery rates for the period 1957–67. The use of more current data would seem desirable. The study "Declining Mortality Among Disabled-Worker Beneficiaries" (Research and Statistic Note No. 13–1974, May 14, 1974), which is inserted in its entirety in Part III (p. 336), indicates a rather sharp decline in disabled worker deaths per 1,000 population, starting in 1970.[5] For the period 1966 through 1969, the annual death rate per 1,000 male beneficiaries was about 75, but in 1970 it declined to 69.0 and in 1971 to 64.8. The Note indicates that a comparison of the data with that for the population in general:

> * * * suggest that the decline in death rates among the disabled-worker beneficiaries is, in part, a function of changes in the composition of the program rather than changes in population mortality trends. This may help to explain the slacking in benefit termination in relation to the number of disabled-worker beneficiaries in current payment status.

Just what is meant by "changes in the composition of the program" is not spelled out in the Note, but it does state that "declining death rates appear to reflect primarily the changes in social security legislation affecting the eligibility of beneficiaries." By this presumably is meant the 12-month duration modification in the definition (1965 amendments) and the insured status liberalization for younger workers (1967 amendment). It is not altogether clear, however, how these provisions would cause a reduction in number of deaths per 1,000 disabled male beneficiaries aged 60–64 from 90.3 in 1969 to 78.2 in 1971. Moreover, it would appear logical that the 12-month requirement would work toward more, rather than fewer, terminations through recovery and should result in relatively fewer beneficiary deaths since, if those awarded benefits are "less disabled" than previously, the overall mortality would be lower.

It should be noted that the efforts of the Social Security Administration's Office of Research and Statistics generally in the disability area appear to have put no particular emphasis on the reasons for the adverse cost experience in the Disability Insurance program nor on the possible cost implications of the disability provisions of the Supplemental Security Income program. Moreover, estimates of the number of applicants for SSI on a State-by-State basis have been greatly at odds with actual experience to date (see Part III, pp. 164–165). Perhaps also related to the "slackening in benefit terminations" is the relatively stable number of people who are being terminated from the rolls after investigation for "continuing disability." In 1973 and 1972, during a period of expansion of the benefit rolls, there were fewer beneficiaries terminated than there were in 1969 and 1970. This is another area which seems to need closer scrutiny.

Finally, the Board of Trustees in the 1974 report noted that "one of the possible ways that the projected short-range excess of outgo over income in the cash benefits funds can be avoided is a reallocation of the total program income among three funds (Old Age and Survivors Insurance, Disability Insurance, and Hospital Insurance) by revising the contribution rates scheduled in present law without increasing the total rate." As stated previously in Part I, the staff recommends against such action, until the Department furnishes a full explanation of the chronic adverse experience of the Disability Insurance program.

During the period 1974–78, the assets of the Disability Insurance Trust Fund are estimated to decline between $0.4 and $0.5 billion. At the end of 1974, they will total 110 percent of estimated expenditures for the following year. By 1978, estimated assets in the fund will total between 60 and 65 percent of annual expenditures.

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[5] The staff has requested Mr. Myers to give this study a thorough actuarial review, including the degree to which it has taken into account duration of disability (which is the most important factor in mortality of the disabled.)

B. STATE AGENCY OPERATION—FEDERAL-STATE STRUCTURE

The Social Security administrative superstructure has always used State agencies in making determinations of disability. An irony of the Supplemental Security Income program—which has often been described as a federalization of the adult categories of welfare—is the fact that as far as the disability aspects of the program are concerned the preponderance of the workload will not fall on Federal employees but on State employees since the same general arrangement will be followed. In recent years questions have been raised by individual State disability examiners and by some State chapters of the National Association of Disability Examiners (NADE) as to whether the continued use of this mechanism is justified for Social Security and SSI disability determinations.

The Social Security disability insurance program is administered under a Federal-State mechanism having its origins in the disability "freeze" provisions of the 1954 amendments to the Social Security Act. Congress at that time indicated that determinations of disability should be made by State agencies, under agreement with the Secretary. As anticipated, State rehabilitation agencies generally carry out this function. The report of the Committee on Ways and Means on the 1954 amendments stated that this method of administration—

> would serve the dual purpose of encouraging rehabilitation contacts by disabled persons and would offer the advantages of the medical and vocational case development undertaken routinely by the rehabilitation agencies (H. Rept. 1698 to accompany H.R. 9366, 83d Cong., 2d sess., p. 23).

This Federal-State administration introduced an entirely new concept in the Federal social insurance system. Unlike the grant-in-aid programs, the relationship between the Department and the States is a contractual one, with no implementing State legislation involved. However, State laws and practices are controlling with regard to many administrative aspects since the personnel are State employees and are controlled by various departments of the State government. The State agencies, acting on behalf of the Secretary of Health, Education, and Welfare, make determinations of disability on the basis of standards and guides provided by the Department. The costs of making the determinations and other aspects of the State disability operations are paid from disability trust fund money by way of advancements of funds or reimbursement to the contracting agency.

Agreements are now in effect with 54 contracting agencies; in South Carolina there is also a separate contracting agency for the blind. The contracting agency designated by the State is the vocational rehabilitation agency, except that in four States (New York, North Carolina, Oklahoma, and Washington) it is the agency administering the public assistance programs, and Arkansas and Idaho have completely separate disability determination agencies.

The Harrison Subcommittee in its report in 1960 stated that it:

> heard testimony to the effect that the basic justification for the Federal-State structure—to give emphasis to the vocational rehabilitation program by strengthening the referral and rehabilitation process and to make use of established relationships with medical and other professional groups—is still sound (p. 6).

It went on to point out:

> The subcommittee is impressed with the effective relationships which have been and are being maintained with the medical profession at the local and national level. This is due, in large part, to the tactful and understanding leadership of the Bureau's Division of Disability Operations and to the work of the Social Security Administration's Medical Advisory Committee. These effective relationships

> would not have been possible, of course, without the cooperative attitude of the medical profession and the American Medical Association.
>
> The medical experts on disability who testified before the subcommittee all agreed that the State agencies should make the determination of disability. This view was also supported by the Amercan-Medical Association which urged that the decentralized administration of the disability insurance program be continued since differences in local customs and conditions require negotiations and arrangements on a State-by-State basis (p. 8).

The Harrison Subcommittee also pointed to adverse testimony to the system of State agency determinations of disability:

> Representatives of the General Accounting Office and of the AFL-CIO and the National Federation of the Blind raised the question of whether the Federal-State arrangement should be modified. The General Accounting Office witnesses observed that the development of the disability claim and the subsequent disability determination are so closely related that the present procedures result in some duplication of work between the Social Security Administration district offices, and the State agencies This situation, they believe, has the inevitable effect of increasing processing time and cost. A representative of the AFL-CIO stated that it seemed more important that the offices making determinations be part of the same agency which has the overall responsibility for administering the disability program, than for these offices to be part of the agency which is responsible for rehabilitation.
>
> The Commissioner of Social Security, William L. Mitchell, testified that the basic Federal-State structure should be maintained at least for the present, although he believes that, from a social insurance point of view, a direct-line Federal operation could be expected to result in simpler and more efficient procedures, with possible improvements in uniformity and processing time. He pointed out that a substantial commitment has been made to State agencies administering the disability program and that it could be seriously disturbing to State rehabilitation programs to withdraw from this arrangement at this time (p. 8).

The Harrison Subcommittee itself was concerned with "substantial interstate variations" in important areas of the disability program and stated that these variations were "inconsistent with the Department's purpose of providing objective, uniform, and equal treatment of disability applicants." The areas cited were (1) denial rates; (2) State cases questioned by the Bureau; (3) rate of purchase of medical evidence, (4) processing time; and (5 case costs and operating methods and procedures. The areas of variation that bothered the Subcommittee in 1960 are still present. The State denial rates show a range by State of from 30 to 56 percent in fiscal 1973. The percent of allowances questioned ranged from 0.3 to 13.6 in 1972—the last year of available statistics. The percent of cases where there was a purchase of medical evidence varied in fiscal 1973 from 55.4 to 8.8.[1] The processing time of initial decision in June of 1973 varied from 16 days to 56 days, and State agency cost per disability case (not counting medical examination) varied from $33 in several States to $83 in Alaska.

This is not to imply that there may not be reasonable explanations for these variations. Undoubtedly the population of the States have different demographic and medical characteristics, but such factors would not appear to account for all of the variation among States. In 1960 the disability system was just getting started; but now that the program is relatively mature further explanations of these variations seem called for.

Those who currently question the continued use of State agencies, such as the Colorado Chapter of the National Association of Disability Examiners, acknowledge that the "State-Federal partnership did serve the intended purpose of utilizing existing expertise in the State (Rehabilitation) Agencies as a transitional device, and the value of referring Social Security Disability Insurance applicants for rehabilitation services has been well established." They argue, however, that this transitional stage is long since over and it "is time to seriously consider whether this hybrid administrative structure has outlived its usefulness." They point out:

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[1] The Social Security Administration's policy on the purchase of consultative exams is not clear. In fiscal year 1973 they were purchased in about 20 percent of the cases as opposed to almost 40 percent 8 years ago. See answer to staff questions as to whether there is a norm of 20 percent (p. 228). See also Disability Insurance Letter No. II-47, Mar. 21, 1974, which seems to deemphasize the purchase of medical examination by State agencies (p. 229).

> that the Disability Determination Units and Disability Examiners have developed a specialized medical expertise beyond that of the rehabilitation counselors of the parent agencies. The disability units are, in fact, in no way dependent on the parent agencies for expertise or other resources, and conversely contribute nothing to the parent agency goals.[2]

The Colorado examiners argue that Congress intended a uniform national system where the "rules, regulations and policies under which disability determinations are made are set by the Social Security Administration, and apply equally in every State and territory."

They believe that the uniformity of administration intended by Congress does not occur. They point out that although the central office in Baltimore can provide policy guidelines and, through its Regional Offices, attempt to influence State agency action, its only real power is through approval of State agency budgets. "All other operational decisions," they maintain, "are made by the Parent State Agency, although the State contributes *no* funds to the program and has *no* interest in the program."

The examiners point to various examples of lack of uniform application of standards:

> 1. The variance of hiring standards for examiners.
> 2. Training of examiners varies greatly.
> 3. Parent agency administrators or state personnel systems may, either arbitrarily or because of undesired effects on the State job classification system, refuse to reclassify or reassign personnel to handle specialized job functions needed to carry out Bureau of Disability Insurance programs—such as quality control.
> 4. Similarly, state administrators frequently block hiring of additional staff to meet the added workloads resulting from program growth even though no state funds are involved.[3]

They go on to point out that there is a control vacuum:

> From these examples, it may be seen that Congress has lost much of its control of the operation of the program. Conversely, it seems unlikely that any significant numbers of State Legislatures involve themselves in this program. The result is that state parent agency administrators have been dealt a degree of arbitrary authority quite inconsistent with our system of Legislative, Judicial, and Executive checks and balances. To the extent that this authority is even occasionally exercised, the intent of Congress is violated and there is essentially no recourse at this time.[4]

The point has also been made of the problems which State employees encounter when they attempt to transfer to other State Agencies or to the Regional or Central offices of the Bureau of Disability Insurance. These difficulties have also hindered the Social Security Administration in seeing that needed staff gets to where the disability workload develops. This has been particularly noticeable in the Supplemental Security Income program, where often the staff has not been where the workload is and the Social Security Administration has been powerless to transfer staff. Similarly, if the Social Security Administration decided that it was desirable to adopt a method of face-to-face contact between the claimant and the disability examiner, this would appear decidely more difficult under a State agency system than in the more flexible system which would be provided by all-Federal administration.

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[2] "Joint State-Federal Administration of the Social Security Disability Program 1972: An Obsolete Partnership?" Colorado Chapter of the National Association of Disability Examiners, p. 2.

[3] Ibid., p. 4.

[4] Loc. cit.

Disability examiners in many State Agencies have noted the great variations in salary levels in the disability program for employees doing the same work. (See Appendix A which shows in tabular form a comparison of the State and Federal salary levels for personnel doing comparable work, and the variation in salary levels between the States.)

The Committee staff has not been able to conduct the type of study of the State Agency structure which would allow it to definitively assess the validity of these various lines of argument. It has, however, examined enough data obtained through written questions addressed to the Social Security Administration to believe that a comprehensive on-site study is needed. Although the Secretary has full authority under contracts with the State Agencies to take over the disability determination duties in the absence of satisfactory performance, this has never taken place during the history of the program. The staff has seen reports of low performance in one agency where it would appear logical that termination would have been under active consideration. In this regard, it should be noted that the termination of an individual State agency agreement would be based on a failure to carry out a contractural obligation while an overall federalization of the program would probably require an amendment of the law. (Additional information concerning the Social Security Administration's role in supervising the activities of the State agencies is contained ni Part III, State Agency Operation, pages 148–237.)

There has been no major Social Security Administration study of the possible federalization of the State Agency operation since 1960.[5] During the consideration of the Social Security Amendments of 1972 the then-President of NADE, Herbert L. Brown, wrote the Director of the Bureau of Disability Insurance that a committee had been appointed by his organization to look into the problem of federalization. Pointing out that the Director would probably want to "remain neutral in these negotiations," Mr. Brown hoped that this "would not prevent you from proposing how it would be carried out when and if the decision is made". The following questions were then posed by Mr. Brown:

> (1) Would an act of Congress be necessary to achieve federalization or could this be handled administratively?
>
> (2) What federal grade levels would examiners, supervisors and administrators have in the federal system?
>
> (3) What arrangements could be made to insure the portability of pensions?
>
> (4) Would we maintain the same supervisory structure and personnel or would federal employees be placed in agencies for purpose of supervision?
>
> (5) Would the states have to ratify any decision to change the current agreements?
>
> Other topics such as appointment, conversion, tenure, leave, seniority, etc., would, I am sure, be of interest to all of us in arriving at what course of action would be best.

The Director of BDI replied to Mr. Brown in a letter dated September 11, 1972:

> As you know, Section 221 of the Social Security Act provides the legal basis for the present Federal-State arrangement of making disability determinations. This section requires the Secretary of the Department of Health, Education and Welfare to enter into agreements with such agencies as are designated by the Governor of each State. Regarding the subject "Federalizing the Disability Determination Units," our interpretation of Section 221 is that a change in the law would be required to accomplish this purpose.

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[5] The need for a study in depth of how the operational aspects of the various State agencies affect uniformity in decisionmaking has been suggested by many commentators. A short summary of some aspects of the so-called Nagi study which attempted to compare the decisions of three State agencies with those made by special study teams is contained in part III. Nagi stated that "trends exhibited (in the research) as well as in earlier findings point out the need for further research in the characteristics of examiners and the organizational settings in which they operate, as sources of influence upon decisionmaking in disability determinations" (p. 89, full citation in part III, pp. 356–358).

> It should also be noted that neither the Department nor the Administration has ever proposed to the Congress a statutory change in Section 221 that would materially affect the present Title II arrangement. Consequently, we have never developed any plans or studies that would enable us to respond meaningfully to your questions concerning grade levels, portability of pensions, supervisory structure, appointments, tenure, leave, etc.

One other area of possible concern is the potential "conflict of interest" of State agencies in making SSI determinations of disability. It is of fiscal advantage to the State for a person to be found disabled under SSI and have the Federal Government finance the basic benefit. Whether these concerns have real substance will be difficult to estimate.[6] They will be tested within the near future, however, when the State agencies examine about 150,000 State aid to the disabled beneficiaries who came on the rolls for the first time after June 1973 and must meet the Social Security definition of disability. A denial means that the individual may have to fall back on some residual State disability program or that of general assistance. On the other hand, it can be argued that the individuals in the State units have developed a high degree of professionalism and independence over the years and any attempt to distort the program toward such an end would be resisted.

The arguments for retention of the State operation are those that have traditionally been made, relating to the rehabilitation of disability beneficiaries and the relationships of the State agencies with the medical profession. Whether the number of beneficiary terminations because of rehabilitation has justified the State Agency structure is a question which is discussed elswhere in this report. The original Congressional belief that the use of vocational rehabilitation agencies was necessary because of their on-going connections with the medical profession may still have validity today. Certainly the program is still having difficulty in getting medical personnel to help in adjudication and in carrying out the very heavy load of independent consultative examinations. Whether this aspect could be carried out more effectively by a Federal agency is an open question. Presumably the personal relationship of DDU personnel with the medical profession would not be disrupted by a transfer from State to Federal control. Whether some doctors would refuse to work in the program because they were dealing directly with Federal personnel is a question worthy of exploration.

Probably one of the crucial questions would be whether federalization of functions now performed by the State agencies would be substituting for an administrative entity with known capacities an operation which, while it might look good on paper, would not necessarily deliver a better product. Those who would pursue this argument could point out that the Social Security Administration seems to have its hands full trying to carry out its responsibilities under SSI and that to transfer the DDU's to Federal control at this time would put additional strains on a system that is struggling with a serious workload crisis.

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[6] Interestingly enough, these same arguments were made by opponents of the cash disability program when it was enacted in 1956.

APPENDIX

Comparison of Disability Determination Unit Salary Levels—State and Federal

Individual State data from "State Salary Schedules of Selected Positions in the Disability Determination Units for Fiscal Year 1973" based on data gathered during October 1972 by Bureau of Disability Insurance, Division of Field Disability Operations.

TABLE A–1.—*Bureau of Disability Insurance and State agency personnel involved in the processing of initial social security disability determinations: comparison of salary levels*

State agencies [1]		*Bureau of Disability Insurance* [3]	
Director or Supervisor of Disability Determination Unit [2]	$14, 227	Director, Division of Initial Claims [4] GS–15	$28, 263
Assistant Director	13, 325	Deputy Director, GS–14	24, 247
		Branch Chief, GS–14	24, 247
First-line Supervisor	11, 470	Section Chief, GS–13	20, 677
Vocational Specialist	10, 358	Vocational Specialist, GS–13	20, 677
Quality Appraisal Specialist	10, 566	Quality Appraisal Specialist, GS–12	17, 497
		Consultant, GS–12	17, 497
Initial Claims Examiner	9, 012	Examiner, GS–11	14, 671
Examiner Trainee	8, 229	Examiner-trainee, GS–09	12, 167
Secretary-Stenographer	5, 839	Secretary-Stenographer, GS–04	7, 198
Typist	5, 082	Typist, GS–03	6, 408
General Clerk	5, 309	Clerk, GS–03	6, 408

[1] Salary listed is median for all SA's based on minimum salary in fiscal year 1974.

[2] State DDU supervisors oversee staffs ranging in size from 10–1,000 personnel with the average agency running between 200–500 people.

[3] Salary level at step 1 of GS ratings as of fiscal year 1974.

[4] Oversees a staff of slightly over 700 persons who in addition to reviewing State disability determinations (DIC prepare determinations in non-State cases) are responsible for the preparation and authorization of benefit awards to "allowed" applicants.

TABLE A-2.—*Range of State agency salaries*

Position	High base pay	Low base pay	Difference	High top pay	Low top pay [1]	Difference	Number of States reporting
Director or supervisor of DDU	$23, 990	$8, 916	$15, 074	$31, 190	$11, 496	$19, 694	52
First-line supervisor of examiners	17, 592	7, 835	9, 757	21, 156	9, 660	11, 496	46
Quality assurance specialist	13, 959	6, 990	6, 969	18, 528	9, 660	8, 868	47
Vocational specialist	13, 426	6, 990	6, 436	18, 528	9, 132	9, 496	42
Reconsideration specialist	13, 426	6, 360	7, 066	16, 570	8, 760	7, 790	40
Initial claim examiner	13, 104	6, 360	6, 744	18, 252	8, 760	9, 492	52
Trainee examiner	9, 855	5, 340	4, 515	11, 838	6, 240	5, 598	33
Stenographer-secretary	8, 220	4, 040	4, 180	10, 320	5, 508	4, 812	52
Typist	7, 008	3, 720	4, 288	9, 515	4, 380	5, 135	50
General clerk	6, 774	3, 600	3, 174	8, 946	4, 728	4, 218	34

[1] Excludes those States with no salary range. These States are included in the "base pay" tables.

TABLE A-3.—*Average salaries for disability positions*

Position	Average base pay	Number of States above average	Average maximum pay [1]	Number of States above average [2]	Number of salaries with no range
Director or supervisor of DDU	$14, 353	16	$18, 092	21	3
First-line supervisor of examiners	11, 272	21	14, 547	22	1
Quality appraisal specialist	9, 580	30	15, 295	9	1
Vocational specialist	9, 860	18	12, 794	20	1
Reconsideration specialist	9, 393	25	12, 315	22	0
Initial claims examiner	8, 707	22	11, 328	24	0
Trainee examiner	7, 577	21	9, 862	20	0
Stenographer-secretary	5, 966	20	7, 839	30	1
Typist	4, 888	28	6, 603	26	0
General clerk	4, 660	17	6, 623	14	1

[1] Average is based on those States that have a range of salary. Those States that have 1 fixed salary for a position were included in the "Average base pay" table.

[2] Does not include those States that have only 1 salary for a position.

TABLE A-4.—*Rank of States in disability personnel salaries*

Position	Alabama	Alaska	Arizona	Arkansas	California	Colorado
Director or supervisor of DDU	44	NR	30	24	5	31
First-line supervisor	31	1	36	40	13	22
Quality appraisal specialist	30	NR	21	NR	10	22
Vocational specialist	24	NR	NR	40	9	17
Reconsideration specialist	19	NR	NR	NR	4	14
Initial claims examiner	19	1	13	NR	3	22
Trainee examiner	10	NR	19	NR	6	13
Stenographer-secretary	44	2	12	48	26	13
Typist	46	NR	17	NR	21	15
General clerk	NR	NR	6	30	15	24
Average overall rank	29. 6	1. 3	11. 7	30. 3	11. 2	19. 3
Average disability determination personnel rank [1]	25. 2	1. 0	11. 8	34. 6	7. 1	20. 1
Average rank of clerical personnel	45. 0	2. 0	11. 6	39. 0	20. 6	17. 3
Projected number of staff employed as of end calendar 1974	216	10	77	106	1, 146	87

Footnote at end of table.

TABLE A-4.—*Rank of States in disability personnel salaries*—Continued

Position	Connecticut	Delaware	District of Columbia	Florida	Georgia	Guam
Director or supervisor of DDU	3	25	4	12	29	42
First-line supervisor	3	NR	9	11	21	35
Quality appraisal specialist	2	4	NR	NR	17	NR
Vocational specialist	1	8	2	NR	15	NR
Reconsideration specialist	1	3	5	NR	9	NR
Initial claims examiner	8	2	4	NR	10	45
Trainee examiner	21	17	25	NR	9	NR
Stenographer-secretary	18	19	8	46	7	NR
Typist	14	13	5	24	10	3
General clerk	8	12	13	NR	3	NR
Average overall rank	7. 9	11. 4	8. 3	23. 2	13. 0	31. 2
Average disability determination personnel rank [1]	5. 5	9. 8	8. 1	11. 5	15. 7	40. 6
Average rank of clerical personnel	13. 3	14. 6	8. 6	35. 0	6. 6	3. 0
Projected number of staff employed as of end calendar 1974	109	23	24	394	213	1

Position	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas
Director or supervisor of DDU	45	8	7	33	14	39
First-line supervisor	NR	14	8	32	7	34
Quality appraisal specialist	41	11	5	19	44	36
Vocational specialist	20	NR	11	36	33	35
Reconsideration specialist	NR	NR	12	13	26	32
Initial claims examiner	26	14	16	39	37	36
Trainee examiner	24	18	8	2	NR	NR
Stenographer-secretary	17	27	30	29	41	40
Typist	21	31	30	35	39	49
General clerk	NR	NR	19	27	31	NR
Average overall rank	26. 4	17. 5	14. 6	26. 5	30. 2	37. 6
Average disability determination personnel rank [1]	22. 2	13. 0	9. 5	24. 8	26. 8	35. 3
Average rank of clerical personnel	14. 5	29. 0	26. 3	30. 3	37. 0	44. 5
Projected number of staff employed as of calendar 1974	35	36	361	196	71	71

Position	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan
Director or supervisor of DDU	13	38	51	15	23	10
First-line supervisor	39	42	43	20	12	10
Quality appraisal specialist	40	39	45	16	26	7
Vocational specialist	39	25	NR	23	18	5
Reconsideration specialist	38	35	336	18	15	NR
Initial claims examiner	48	46	44	17	21	9
Trainee examiner	32	30	NR	16	5	1
Stenographer-secretary	32	52	34	16	10	5
Typist	18	40	22	7	4	2
General clerk	NR	NR	NR	5	NR	2
Average overall rank	32. 4	33. 7	39. 2	15. 3	14. 8	5. 6
Average disability determination personnel rank [1]	35. 5	30. 2	43. 8	17. 8	17. 1	7. 0
Average rank of clerical personnel	25. 0	46. 0	28. 0	9. 3	7. 0	3. 0
Projected number of staff employed as of end of calendar 1974	145	257	43	152	186	369

See footnote at end of table.

TABLE A-4.—*Rank of States in disability personnel salaries*—Continued

Position	Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada
Director or supervisor of DDU	21	37	17	NR	43	18
First-line supervisor	28	24	4	NR	29	17
Quality appraisal specialist	15	25	3	20	24	12
Vocational specialist	26	38	3	21	NR	10
Reconsideration specialist	20	33	11	17	21	NR
Initial claims examiner	28	40	6	33	26	7
Trainer examiner	NR	15	NR	26	NR	NR
Stenographer-secretary	NR	36	50	NR	35	6
Typist	38	NR	47	23	45	NR
General clerk	22	23	NR	18	29	NR
Average overall rank	23. 7	30. 1	17. 6	22. 5	31. 6	10. 0
Average disability determination personnel rank [1]	21. 6	30. 2	7. 3	23. 4	28. 8	10. 6
Average rank of clerical personnel	30. 0	29. 5	48. 5	20. 5	36. 3	6. 0
Projected number of staff employed as of end calendar 1974	105	136	152	31	57	26

Position	New Jersey	New Hampshire	New Mexico	New York	North Carolina	North Dakota
Director or supervisor of DDU	9	47	47	2	22	50
First-line supervisor	4	NR	38	2	41	44
Quality appraisal specialist	31	38	33	1	34	46
Vocational specialist	27	NR	32	7	22	41
Reconsideration specialist	22	NR	25	8	29	NR
Initial claims examiner	24	35	23	11	34	NR
Trainee examiner	11	NR	12	3	22	NR
Stenographer-secretary	31	28	37	3	1	33
Typist	11	26	37	19	36	43
General clerk	16	NR	9	NR	25	NR
Average overall rank	18. 7	34. 8	29. 3	6. 2	26. 6	42. 8
Average disability determination personnel rank [1]	18. 4	40. 0	30. 0	4. 8	29. 1	45. 2
Average rank of clerical personnel	19. 3	27. 0	27. 6	11. 0	20. 6	38. 0
Projected number of staff employed as of end calendar 1974	331	28	45	775	153	21

Position	Ohio	Oklahoma	Oregon	Pennsylvania	Puerto Rico	Rhode Island
Director or supervisor of DDU	6	1	34	11	40	46
First-line supervisor	18	46	30	19	34	25
Quality appraisal specialist	9	47	18	14	NR	13
Vocational specialist	14	42	16	12	37	NR
Reconsideration specialist	6	39	24	7	40	NR
Initial claims examiner	29	50	25	12	52	30
Trainee examiner	14	31	NR	7	33	NR
Stenographer-secretary	4	43	38	23	51	22
Typist	16	42	NR	6	50	9
General clerk	14	NR	NR	11	34	10
Average overall rank	13. 0	37. 8	23. 1	12. 2	42. 4	22. 1
Average disability determination personnel rank [1]	13. 7	36. 5	24. 5	11. 7	41. 1	28. 5
Average rank of clerical personnel	10. 0	42. 5	38. 0	13. 3	45. 0	17. 0
Projected number of staff employed as of end calendar 1974	334	99	119	445	138	44

See footnote at end of table.

TABLE A-4.—*Rank of States in disability personnel salaries*—Continued

Position	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont
Director or supervisor of DDU	20	36	41	16	28	48
First-line supervisor	15	NR	33	6	16	NR
Quality appraisal specialist	28	NR	32	6	8	35
Vocational specialist	19	NR	28	4	6	NR
Reconsideration specialist	27	NR	23	2	10	31
Initial claims examiner	38	15	41	5	18	31
Trainee examiner	28	NR	NR	NR	NR	NR
Stenographer-secretary	20(VR) 9(B)	47	45	24	25	21
Typist	20(VR) 33(B)	NR	44	34	25	28
General clerk	NR	32	17	NR	10	7
Average overall rank	23.8(VR) 24.1(B)	32. 5	32. 7	12. 1	16. 2	21. 8
Average disability determination personnel rank [1]	33. 0	25. 5	31. 5	6. 5	14. 3	24. 2
Average rank of clerical personnel	20.0(VR) 20.5(B)	39. 5	35. 3	29. 0	20. 0	18. 6
Projected number of staff employed as of end calendar 1974	153	21	172	471	32	20

Position	Virginia	Washington	West Virginia	Wisconsin	Wyoming
Director or supervisor of DDU	NR	32	27	19	52
First-line supervisor	37	23	26	21	NR
Quality appraisal specialist	37	23	27	17	NR
Vocational specialist	36	35	19	15	NR
Reconsideration specialist	34	28	16	9	NR
Initial claims examiner	42	32	47	10	43
Trainee examiner	27	NR	29	9	20
Stenographer-secretary	39	14	49	7	42
Typist	41	8	27	10	NR
General clerk	28	4	21	3	NR
Average overall rank	33. 3	22. 1	28. 8	12. 0	39. 2
Average disability determination personnel rank [1]	35. 5	28. 8	27. 2	14. 2	38. 3
Average rank of clerical personnel	29. 0	8. 6	26. 3	6. 6	42. 0
Projected number of staff employed as of end calendar 1974	240	149	119	147	11

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[1] Includes the first 7 positions listed in this tabulation.

NOTE.—NR—Not reported; VR—Vocational rehabilitation unit; B—state agency for the blind.

C. REVIEW OF STATE DETERMINATIONS OF DISABILITY

The Federal-State structure of the disability program was discussed generally in the previous chapter. The issue of whether and to what extent the Federal Government should review the individual disability determinations of the State agencies for uniformity of decision and change determinations warrants special consideration. This is so because new questions about the role of the State and Federal Governments have been raised by a number of developments in recent years, including (1) a decision to go from 100-percent Federal review of State agency determinations to a small sample of cases, (2) a decision to review a sample of SSI cases in the regional offices rather than in Baltimore, and (3) a growing number of persons receiving disability benefits, caused by a higher incidence rate and lower termination rate, and a resulting increase in the actuarial cost of the Disability Insurance system.

SAMPLE METHOD

At the time of the Harrison Subcommittee study the administration was recommending that the Social Security Administration be given the authority to reverse denials as well as allowances. Actually in practice the Social Security Administration examined both allowances and denials and returned the cases it questioned to the State agencies with comments. This was followed either by concurrence with the Social Security Administration's opinion on the case or there was more negotiation back and forth. At the time of Harrison, most State agencies looked at this procedure as the primary vehicle for the transmittal of Bureau policy on the determination of disability. Over the length of the program, the rate of return of cases had been in the neighborhood of 5 percent or 6 percent nationwide. (For individual States in 1970–71 it was as high as 10 percent and as low as 3 percent.) In the period 1959–67 it appears that a higher percentage of denials was being questioned, while from 1968 on it appears that a higher percentage of allowances was being questioned. (See Social Security Administration's explanation of reason for this development in part III, State agency operation, review of State agency cases, sample review and quality control, p. 206.)

In 1972 the Social Security Administration switched from a case-by-case review of State agency determinations to what can be roughly described as a 5-percent sample. The basic legislation which authorizes review and reversal of State agency determination is phrased in discretionary terms but the 100-percent review procedure was one of long standing and one which the Social Security Administration had emphasized before congressional committees. The language of the act states that "the Secretary may on his own motion review a determination made by a State agency * * * that an individual is under a disability * * * and as a result of such review, may determine that such an individual is not under a disability * * * or that such disability began on a day later than that determined by such agency, or that such disability ceased on a day earlier than that determined by such agency." (Sec. 221(c)). The Conference report on the 1956 amendments stated significantly:

> In providing in the conference agreement that determinations of disability for cash disability benefits be made by State agencies under the same arrangements as are now utilized in making determinations for the disability freeze, it is understood and expected that the Secretary of Health, Education, and Welfare will fully utilize his authority to review and revise determinations of State agencies in order to assure uniform administration of the disability benefits and to protect the Federal Disability Insurance Trust Fund from unwarranted costs.[1]

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[1] H. Rept. 2936, 84th Cong., p. 26.

In a context of growing Black Lung caseload and Administration efforts to reduce Federal employment, the Social Security Administration made the decision to go to the review of a sample of disability cases. In answer to a question of the Senate Appropriations Committee as to why they went to a sample and what was the quality of State decisions, the Social Security Administration stated:

> When the program was initially established we thought it important to review both allowances and denials because decisions were being made by 56 different entities—in some States separate agencies handle blind cases—and we wanted to be sure that there was consistency among the States in applying national standards. As the States gained more experience, we gradually reduced the number of cases reviewed—about 60 percent of the total was planned initially for the current fiscal year [1972].
>
> A combination of events this year resulted in our decision to go from a review of 60 percent of the cases to a 5 percent sample review which we think should be adequate for quality control purposes. One of the important factors was the large backlog of black lung reconsideration cases which the employees performing the review function could be trained to handle. Also, we had a serious backlog in correspondence. We needed to clean up these backlogs promptly in order to handle major increases in work expected with new legislation. This work situation coupled with efforts to reduce employment in Government expedited our movement to a sample review. I might add that we are taking additional quality control measures in the State agencies to reinforce the accuracy of their decisions.[2]

In answer to a staff question as to what studies or bodies of fact or opinion were relied upon in making the decision to go to the sample review, the Social Security Administration stated:

> BDI moved away from the 100-percent review procedure when it became apparent that there had been a levelling off of the rate of progress of State agencies in improving the quality of their disabiltiy determinations, in an effort to devise quality assurance techniques which would be more efficient and effective. A key concept in the shift to sample review was that State agencies must accept greater responsibility for self-assessment of the quality of their work and for self-improvement based upon such assessment. It was believed that in the long run sharing this responsibility with the State agencies would produce better results than simply continuing the 100-percent review activity.

The Social Security Administration argues that its sampling methods give it an adequate check on the operations of the State agencies and that it can give more substantive policy guidance by its review and comments on a smaller number of cases. (See pt. III, p. 189, for SSA description of various sampling techniques and their assessment of their effectiveness.) On the other hand, the statistics before the 1972 decision to adopt the 5-percent sample indicate that a fairly substantial number of State agency decisions were being questioned, returned, and the decision actually changed.[3] For instance, in the first 6 months of 1971 over 10,000 State allowances were questioned and about 4,000 of these were eventually denied. This presumably was based on a 60-percent review. Applying the same proportion to a 100-percent review, another 2,700 cases would have been denied. On the other hand, if the 5-percent sample had been in effect, only 336 State allowances would have been changed to denials.

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[2] Hearings before the Committee on Appropriations, Labor-HEW appropriations, fiscal 1973, pt. 4, pp. 4047–48.

[3] The history of Social Security Administration review of State disability decisions shows that, over the years, there has been more questioning of allowances than denials. Thus, this operation overall has had the effect of saving the trust fund money. The statistics also show, however, that State agencies appear to acquiesce in a higher percentage of cases where it is suggested by SSA that a denial be made an allowance. This is true even though SSA has no authority to call for this result. Ironically, where SSA does exercise reversal authority in the allowance to denial situation, the statistics indicate that the States fight harder to preserve their initial determinations.

Similarly, as to changes of State agency denials to allowances, in the 6-month period, there would have been 5,135 under the 100-percent review, but only 257 under the 5-percent sample. Actually in the first 6 months of 1971, there were 3,080 denials changed to allowances under the 60-percent review mechanism. Under the sample in the period 1972–74, there have been a higher percentage of reviewed cases questioned (about 18 percent), and in contrast to previous experience more of these have been allowances than denials. The Social Security Administration maintains that this is due more to the intensity of the review rather than to more adjudicative errors. According to SSA, a sample of the sample shows that in about 30 to 35 percent of the returned cases the decisions are changed.

The Social Security Administration seems to be trying to follow a course between two opposing philosophies of administration. The first is that of individual review of specific State agency disability decisions with the ability to return and change the decision where there is disagreement. The second is a sample review which is intended to detect patterns of deficiencies in State agency operation. The current system seems to have a little of both—a sample review with negotiated change on the few cases sampled. Moreover, in the SSI cases the decisions are effectuated prior to review of the sample, further inhibiting any inclination to change decisions.

One other recent development that is rather confusing from a policy standpoint is the use of the medical consultants in Baltimore to review the sample cases. Under the pre-1972 system these physicians reviewed a small sample of cases primarily for purposes related to the development of the standards for medical evaluation. The physician sample which existed in the years of the 100-percent review appears to have questioned more allowances than did the lay evaluators. However, those physicians were also available whenever the disability reviewers needed advice and they reviewed all cases where the primary import was medical development. Now, however, the disability reviewers (who numbered over 200 in the days of 100-percent review), are nearly extinct and their function in reviewing State agency decisions has been taken over by the medical consultants. Under SSI in the regions, however, State agency case review seems to be following the pre-1972 Baltimore model with disability reviewers carrying out the primary review function and consulting with the medical consultant when medical questions are involved. (Review of State agency determinations of supplemental security income (SSI) disability decisions will be carried out by the personnel of the Bureau of Disability Insurance in the 10 regional offices of the Department of Health, Education, and Welfare. It will be reviewed on a 7-percent sample basis.)

The questions which arise about such a system are obvious. First there are two mechanisms doing the same thing, albeit in a different manner—the central office in Baltimore checking title II determinations and those where there are applications under both programs, and the regional offices checking SSI determinations. (There are indications that eventually all cases are to be checked by the regional offices, although this has not been officially stated as a Social Security Administration objective.) The idea of creating 10 [4] Mini-Bureaus of Disability Insurance may make the institution of uniform policy even more difficult to achieve. The present disability determination system is undoubtedly one of the most complex governmental arrangements in existence. (See flow charts for initial determination under social security and SSI in pt. III, pp. 138–139.) To now make this a central office, regional, and State arrangement is a fairly major step and somewhat anomalous in the so-called Federal social security system.

In the central office in Baltimore it was relatively easy to call in the heads of the review units to discuss policy development and problem areas with various State agencies. Under the new system it will be necessary to bring in regional personnel from all over the United States for such discussions. Moreover, there would appear to be a fuzziness of organizational responsibility which may lead to growing feelings of autonomy by the regional units. The combination of fairly independent State units reviewed by semiautonomous regional units operating under general instructions of the central office in Baltimore might tend to intensify existing problems.

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[4] There are currently 10 HEW regional offices: Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco, and Seattle. By mid-February there were a little over 400 employees in BDI regional offices and 750 are scheduled to be employed by the end of the fiscal year. Over 300 of those are to be in the Claims Review Sections.

Finally, it has to be noted that allowances have accelerated during the period after the sample review system was initiated. It is clear that the Social Security Administration cannot reverse cases that it does not see. With these considerations in mind, the committee may wish to have examined more closely the question of the effectiveness of the controls the Bureau of Disability Insurance has over the State agencies and whether under the new sample "quality assurance" system it has the ability to detect and react to trends of adjudications which are at odds with the standards for a uniform Federal program.

D. DISABILITY APPEALS PROCEDURE

The multilevel social security appeals procedures have raised a number of issues over the years. The procedures cover the Social Security Act's retirement, survivors, disability, and medicare programs, but over 80 percent of the appeals are in the disability area. The length of time involved in processing a Social Security appeal has already been discussed. Although the latest figures available show an improvement in processing time over the situation the Harrison Subcommittee encountered in 1959–60, the added workload resulting from SSI appeals could quickly undo the progress that has been made.

The Harrison Committee noted many of the problems in the appeal areas and the 1967 amendments attempted to reverse some disturbing judicial interpretations of the law. Robert G. Dixon, in his book "Social Security Disability and Mass Justices," which was based on a study for the Administrative Conference of the United States, raises the question as to whether such appeal mechanisms may result in the final epitaph for the United States reading "Died in litigation, circa 2000 A.D."

Critics of Dixon would reject his highly printable quotes which predict doomsday through litigation and his general observations that the solution must be found in greater conformity and the ability to deal with extremely high volume. They would point out that the Congress decided that the Social Security disability determination was to be a highly individualized operation and the appeals system was established to protect the basic rights of the claimant. They would favor more modest modifications of the present system to make it more rational and effective.

Some areas of concern with respect to the appeals procedures are:

1. the escalation in the number of disability claims;
2. the advent of SSI and its effect on the Social Security process;
3. the growth in the hearing examiner corps (more than one-half of all hearing examiners in the Federal Government); and
4. the burgeoning disability case load in the U.S. courts. Also of importance is an indication of an apparent lack of positive correlation between the many layers of review which raises questions of the equality and fairness of treatment received by claimants under the disability program.

Hearings and Appeals Process in Brief

If a claimant is dissatisfied with an initial denial of disability by the State agency he can request a reconsideration within 6 months of notice of denial. The reconsideration is also carried out by the State agency but by personnel other than those who made the initial determination. If upon reconsideration the claimant is again denied benefits he will be given a hearing before an administrative Law Judge (ALJ) if he files a request within 6 months of notice of the denial. Under SSI this period will be 30 days at both levels. Prior to 1960 an individual could request either a hearing or a reconsideration. If the claim is denied by the administrative law judge, the claimant has 60 days to request review by the Appeals Council. The Appeals Council may also, on its own motion, review a decision within 90 days of the ALJ's decision. The Appeals Council may review, affirm, modify, or reverse the decision of the ALJ or it may remand it to the ALJ for further development. The claimant is notified in writing of the final action of the Appeals Council, and is informed of his right to obtain further review by commencing a civil action within 60 days in a District Court of the United States. (These four decisional levels do not take into account the review of State agency decisions, both of initial determination and reconsideration, by the Social Security Administration.)

The Bureau of Hearings and Appeals has grown to an agency with a staff of 2,044 employees and a budget of $43 million a year. In 1960 it had a budget of $4 million and 426 employees, and, even more significantly, a budget of $21.8 million and 1,278 employees in 1970.

District court caseloads are running at an increasingly high rate. The number of pending Social Security disability cases jumped from just over 3,000 in January of this year to almost 4,200 by July.

LEVELS OF REVIEW AND REVERSALS

A summary look at appeal statistics highlights the wisdom of continued appeal. Reversals of initial decisions upon reconsideration are still substantial (about 30 percent), and hearing examiner reversals of SSA denials are running in the neighborhood of 53 percent. Cases which go to hearings today are twice as likely to ultimately result in benefit payments than was the case in 1960 even though the Government now has a much higher affirmance rate in courts. This is due to the fact that in 1960 the hearing examiners were only reversing the State agency determinations in 24 percent of the cases.

The appeals caseload is made up primarily of cases which involve the application of nonmedical standards. Dixon questions whether the multileveled review of these cases result in more uniform and just decisions and puts forth a theme that keeps recurring throughout his book that lack of personal contact with the claimant at the State agency level is linked to the frequency of appeal and the high reversal rate at those levels which deal directly with disability claimants. On this point he states:

> In the SSA-type administrative decisional process, for a borderline case the guess of the first decisional body may be as good or reliable as the guess of an appellate body two or three steps up the ladder, provided the first decisional level operates in the same fashion as the higher body, i.e., in personal confrontation wih the claimant. This is not the case in SSA, and herein perhaps lies the reason for the reluctance to attribute more finality to the basic decisional stage and thus pave the way for eliminating much of the hearing examiner and appellate structure. SSA Baltimore decides on the record only, without seeing the claimant.
>
> A related observation is that the reversal rates mentioned above, at least on present evidence, cannnot be justified as a contribution to the basic "justice" of the system. If anything, it may imbalance the system in favor of those who yield to traumas and reinforce the very kind of conduct society should seek to discourage. The reversals in the observed hearing examiner level hearings and in various cases perused seems to be a complex of the following: (a) the inherently amorphous nature of the abstract-capacity-for-employment standard when applied to the walking wounded; (b) the borderline fact situation in most of the cases that fall outside some Baltimore-created per se rules; (c) the difficulty in assessing psychological overlay in all of the borderline cases; (d) the conclusionary testimony (even though supposed to be avoided) of a medical advisor, which once given cannot be ignored; (e) the naturally appealing nature of the face-to-face contact, which first occurs at the hearing examiner level; (f) the presence of an attorney who in any borderline case can always make a plausible argument and by his mere presence threaten a further appeal; (g) the natural desire of an appellate body to justify its independence, which in the SSA context can only be exercised by ruling in favor of the claimant: and (h) at the court level ignorance or simple nonacceptance of the statutory standard of disability.
>
> In defense of reversals, even at fairly high rates, it can be argued that they are good, that they evidence correction of poor work at lower levels. This point is undoubtedly in part valid, and Justice Blackmun apparently was hypothesizing something of the sort when he cited the 44.2 percent hearing examiner reversal rate as attesting to "the fairness of the system." [1]

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[1] Staff Note: From the Supreme Court case of *Richardson* v. *Perales* (1971) 402 U.S. 387, 1432—actually the thought comes from the Justice Department brief. The hearing reversal rate was about 53 percent for calendar 1973.

> There are problems, however, with this hypothesis if pushed too far. Only a fraction of the total denials reach the hearing examiners. Can one assume that the unreviewed decisions were correct or only that there is differential claimant vigor? More significantly, such data as is available on consistency among hearing examiners suggest that a reversal may depend significantly on the personality of the examiner as well as the actual record. A significant cluster of examiners has reversal rates of 20–35 percent, and another significant cluster has reversal rates of 56–80 percent. Such data does not so much attest to fairness as add a new element of unfairness—the chance factor of case assignment to a particular examiner. And again the crucial factor—pending better studies than are available now—seems to be not bad faith but honest differences of opinion under the vagaries of the national economy-total disability concept (pp. 134–135).

Suggested Alternatives—Dixon, Horsky, and a Little Harrison

EARLIER FACE-TO-FACE CONTACT

As would be expected from the material already presented, Mr. Dixon's suggested changes are predicated on the idea that there should be face-to-face contact between the claimant and the adjudicators early in the decisional process. He believes this will reduce appeals and help to identify psychological problems which are intertwined in most borderline cases. He notes that such a development implies more decisional authority at the State agency level, but at the same time worries that "major regional inconsistencies" may arise because of different applications of the vague standards of disability. With these considerations in mind, Dixon presents a number of alternatives:

1. Face-to-face contact at the reconsideration level using State agency teams—and these teams might contain one lawyer and one physician rather than the current practice of a lay determiner and a physician.

2. Similar face-to-face contact but through a decentralized Bureau of Insurance Disability staff arrangement.[2] "Decentralization could take the form of permanent local substations in each State or roving teams of reconsideration personnel on a regular basis (the latter being preferable in order to maintain uniformity and avoid differentials). Some replaced State expert personnel could be absorbed as part of the reconsideration staff expansion that might be needed." Mr. Dixon states that the teams would consist of a lawyer for record-building pruposes, a physician, and a lay person trained in disability evaluation. He would consider this the final agency determination which would eliminate the hearing examiner stage, but he would preserve an expanded Appeals Council for what would be truly an appeals function. The council would have discretionary power to grant review only in selected cases. Mr. Dixon notes that Alanson W. Willcox, former General Counsel, Department of HEW, was in general support of this approach and had commented that if an adequate record of oral evidence could be developed with other procedural safeguards "the proposal to abolish the APA (Administrative Procedure Act) hearing on the issue of disability seems to be worthy of serious consideration." Mr. Willcox, however, would preserve judicial review with as strong a "substantial evidence" rule as possible. (The issue of limiting the Appeals Council strictly to a review function will be discussed later.)

Realizing that the deletion of the hearing examiner stage would be a controversial step, Mr. Dixon states that:

> A variant of this suggestion would be to fuse the two functions with the hearing examiner serving as presiding and deciding officer and the other members of the multidisciplinary panel serving as advisors. To go beyond this and incorporate the independent SSA hearing examiner as the presiding but coequal member of a multidisciplinary reconsideration panel probably would be deemed to require amendment of the Administrative Procedure Act (p. 147).

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[2] Since the Dixon book was published in early 1973, there has been a major expansion of Bureau of Disability Insurance (BDI) regional disability staff.

Critics of the Dixon approach would question the practicability of the proposal particularly in view of the magnitude of the Social Security and SSI appeals workload. In fiscal 1975 it is estimated that there will be 250,000 reconsiderations of initial State Agency determinations. Assuming that the necessary staff of hearing examiners and administrative law judges could be supplied, which is a large assumption if the difficulties in obtaining SSI examiners continue, it is doubtful that it would be possible to employ the physician members required for these teams or panels. The State Agencies, over the years, have found it quite difficult to hire physicians for disability determination work, and the manpower requirements of such a team approach might well be impossible to meet.

STATE AGENCY RECONSIDERATION INTERVIEW STUDY (SARIS)

In the area of face-to-face contact, an interesting study entitled "State Agency Reconsideration Interview Study" (SARIS) was carried out by the Social Security Administration in 1971 to determine if a personal interview between the claimant and disability examiner at the State agency reconsideration level would result in more complete development of cases, better claimant acceptance of the decision, and a subsequent reduction in the number of appeals. Although the experiment was marred by different procedures used by the five State agencies participating and certain biases in the selection of the cases, the results did show a rather significant increase in the allowances rate for the cases with a personal interview and lower reversal rate on appeal for this type of case. On the other hand, almost as high a percentage of the interviewed cases requested a hearing as those who were not interviewed. The following table gives a breakdown of the 1,255 randomly sampled cases which had been through the regular reconsideration procedures and whose initial denial was ready to be affirmed by the State agency:

	Interview cases		Noninterview cases	
	Number	Percent	Number	Percent
Total number of denials	671		584	
Denials changed to allowances	132	19. 6	8	1. 3
Denials upheld	539		576	
Requested hearing	214	39. 7	241	41. 8
Decision changed at hearing	46	22. 2	73	37. 2
Decision change—total cases, reconsideration and hearing	178	26. 0	81	14. 0

The Social Security Administration rejected this procedure on a "nationwide, mandatory basis" although it stated that "most States are now using the telephone to contact reconsideration claimants where there is a question unanswered or it appears that additional sources may exist." The administrative implications of such a system were described by SAA as follows:

> Most optimistically, a State agency examiner might review the file and interview four claimants each day, provided these claimants could be scheduled for their interview at a central location. If travel to several locations were necessary, this figure would be correspondingly lower. Projections as a result of SARIS show that a minumum of 254 additional examiner-years would be necessary for each 100,000 reconsideration interviews to conduct interviews only in the metropolitan areas. Should States conduct the interviews Statewide, this projection might be increased by as much as 50 percent because of travel time and other time-consuming factors.

(A full summary of the State Agency Reconsideration Interview Study is contained in pt. III., pp. 240–243). See also the discussion of the new "informal" and "formal" conferences provided by regulations for the SSI program in this same section.

ELIMINATE MANDATORY RECONSIDERATION

In 1960 the requirement of a mandatory reconsideration had just been imposed by the Social Security Administration. Prior to then, the claimant had the option of either having a reconsideration or going directly to hearings. It is interesting to note that even in those cases where the claimant had opted to go straight to a hearing (less than 20 percent of the cases) there was an "informal remand" for further development where there was a likelihood of reversal by the hearing examiner. At the present time, there is contemplated a similar[3] type of remand in SSI cases even in cases where there has been a reconsideration. (See pt. III p. 252 for a description of this projected procedure by the Social Security Administration.) Mandatory reconsideration was questioned in the Harrison Subcommittee's report which stated that the question "of whether a claimant becomes exhausted in the process of exhausting his administrative remedies is always a real one."

The Subcommittee stated in its report:

> *The subcommittee believes it is particularly important that an individual desiring a hearing should not be required to go through the reconsideration process if it means a substantial increase in overall processing time and, with this in mind, we request that the Department watch the process of mandatory reconsideration very closely and report to the committee on its operation.*
>
> A number of hearing examiners in the subcommittee's survey questioned the legality of a mandatory reconsideration inasmuch as section 205(b) of the Social Security Act states:
>
> "Upon request by any * * * individual * * * who makes a showing in writing that his or her rights may be prejudiced by *any decision the Secretary has rendered, he shall give* such * * * individual reasonable notice and opportunity for *a hearing with respect to such decision*, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision." [Italics original.]
>
> This contention appears to be worthy of further study. It should be noted that, at the reconsideration level where new evidence is frequently submitted, the claimant is not allowed to see the initial determination or the evidence upon which it is based; but, upon request, can get summaries prepared by the Bureau. At the hearing stage, on the other hand, the claimant or his representative is entitled to look at the determination and pertinent parts of the record (p. 33).

The report by Covington and Burling[4] on the appeals process (the Horsky report) reached the conclusion that the procedure was legal declaring it was based on authority in both 205 (a) and (b) of the act and that the Congress intended to give the Secretary the authority to make, in Horsky's words, "such investigations as to him were necessary and appropriate before 'rendering' the final administrative decision from which a review by way of hearing is provided" (p. 403). The report took no position on the wisdom of the procedure but suggested that the matter should be "studied * * * after it has been in operation for a few more years."

Three years after the Horsky report, the George Washington Law School issued a report which dealt at considerable length with mandatory reconsideration. It came to a different interpretation of the law, believing that mandatory reconsideration undermines the State agency's right in the statute to have its denial of benefits be the "final" decision of the Secretary which is subject to a hearing. This report states:

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[3] As of late May no reconsiderations had been completed on the new SSI disability program although initial decisions had been made almost 6 months earlier. This means that so far no SSI applicants have yet been able to request a hearing.

[4] "The Operation of the Social Security Administration Hearing and Decisional Machinery," Covington & Burling, Charles A. Horsky, Amy Ruth Mahin (mimeopgrahed) 462 p. It should be noted that the Social Security Administration has not printed or distributed this study. This is also true of the 3 volume 1963 work of the faculty of the George Washington Law School, "The Social Security Administration: An Interdisciplinary Study of Disability Evaluation," which is quoted at length in the following pages of this section. These were major research projects of the Social Security Administration which have relevance to persons concerned with the appeals process. One has to question a policy which has effectively removed this scholarship from the public domain.

> We have examined the legislative history of the Social Security Act, as well as the appropriate sections of the statute, and find nothing therein which suggests that the Secretary is authorized to regard the State Agency determination as his "tentative" decision to any greater extent than he would so regard other decisions in the administrative review process, all of which are subject to revision or reversal upon timely appeal by the claimant. Nevertheless, it may be correct to say, and the Horsky Report so finds, that in the regulations establishing the mandatory reconsideration policy "the Secretary does no more than state that he has not rendered any decision on a claim until he has had an opportunity to give the claim further consideration in the event his initial or tentative decision is unacceptable." To adopt this view, however, is to accept the contradiction arising from Section 221 which states in subsection (a) that the initial denial by the State Agency is the "determination of the Secretary" and further in subsection (d), that "any individual dissatisfied with any determination under subsection (a), (c), or (g) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in Section 205(b)". As quoted above, 205(b) refers to "any decision the Secretary has rendered." Therefore, in our opinion, "a determination by the Secretary" under Section 221(a) which he may not subsequently review on his own motion, has achieved that degree of "finality" necessary to bring it within the ambit of the "hearing" which the Secretary must accord upon timely request by a dissatisfied claimant. (P. 225, pt. 1, sec. 1.)

The G.W. Law study group notes that after a year of experience, the Bureau of Old-Age, Survivors, and Disability Insurance sent a favorable report on mandatory reconsideration to the Commissioner of Social Security in 1961. The following is a description of the report and the G.W. Law critique.

The OASDI report stated that mandatory reconsideration was justified for the following reasons:

(a) *Public acceptance.*—Only two objections to complying with mandatory reconsideration were received out of 36,850 claims processed during the period October 24, 1959 to September 30, 1960.

(b) *Better protection of claimants rights.*—This was thought to result from the more thorough development and consideration of the claim for benefits.

(c) *Savings of time and administrative expense.*—This conclusion was based on a finding that in the 12-month period ending September 30, 1960, 41 percent of those reconsidered were allowed. These persons, therefore, had obtained their benefits in a proceeding which required an average elapsed time of 100 days as compared with 180 days to process a claim through the hearing examiner level. It was further noted that average processing time of hearing requests had drastically declined since October 1959, when mandatory reconsideration had become effective, and this was thought to have resulted from the better documentation at the reconsideration level.

The G.W. report stated that "the foregoing conclusions, if valid, lend support to the Secretary's decision; however, we are not entirely persuaded that some of the facts cited support the conclusions derived therefrom."

With respect to the public acceptance argument the Law Group wrote:

> It would appear that mere public compliance with lawfully issued regulations of the Secretary does not necessarily warrant the conclusion that the public thereby accepts or approves the procedures which the regulations establish so long as the regulations contain no provision for noticing an objection or authorizing any official response thereto should one be raised.
>
> Under the circumstances confronting the great majority of disability applicants following their initial denial, it would be unreasonable to expect them to voice objection to the next procedural step in the administrative review process when this action could serve no useful purpose and might conceivably prejudice the very tribunal that was to reconsider their claim. Had the regulations contained some provision for waiving compliance with reconsideration

> and thereby eliminating this step as a procedural condition precedent to a "hearing", it might be possible to draw some valid inference from a seeming indifference of the general claimant population.
>
> Of greater significance is the fact that prior to October 24, 1959, when claimants had the option of bypassing reconsideration, some 80 per cent of those requesting reviews elected to have their cases reconsidered by the State Agency in lieu of proceeding directly to the hearing level.
>
> * * * * * * *
>
> * * * the fact that the great majority of applicants elected to prosecute their appeal through the reconsideration process would not appear to justify the decision to require the remaining minority to forego the shorter path to administrative finality and, consequently, an earlier opportunity for judicial review in event of an adverse State Agency determination. Those applicants who have confidence in the merits of their claim, notwithstanding initial denial, may well prefer to waive the opportunity for an earlier but intermediate decision at the reconsideration level in favor of reaching a final administrative determination at a somewhat later point in time via the hearing process. There are advantages inherent in either course. (P. 233–235.)

With respect to the argument that reconsideration better protects the claimant through the more thorough development and consideration of his case the G.W. report stated:

> Opinion differs on the question of whether it is reasonable to expect the foregoing development to be accomplished concurrently with the initial determination rather than at some subsequent review stage in the appellate process. The Secretary has decided on the latter course, and his judgment is deserving of the most careful consideration in view of the expertise which he has developed as a result of experience with alternative approaches to the problem of administrative adjudication of disability. Nevertheless, there are those who base their objection to mandatory reconsideration on both observation of the process and practical experience with its procedures. These critics deny that this measure affords any significant degree of protection which the applicant did not previously enjoy when he had the right to by-pass this level in favor of a hearing before an Examiner of the Bureau of Hearings and Appeals. They point out that under *optional* reconsideration the claimant sacrificed none of his substantive rights with respect to the introduction of new evidence and the further development of his case when he elected to proceed directly to the hearing level. With this choice available, he had the opportunity of saving the entire time consumed by the reconsideration process, provided the Division of Disability Operations did not unduly delay the submission of his case by virtue of the "informal remand" practice previously discussed. (P. 236–237.)

The G.W. report also expressed some reservations as to the validity of the argument that it saved claimant's time:

> The third major conclusion which BOASDI derived from its first year's operational experience with mandatory reconsideration was that it resulted in saving the claimant's time as well as Bureau administrative overhead. Certainly this would appear to be true if one looks only at the current cumulative figure of a 34 percent allowance rate for those reconsidered and ignores the consequence of denying the remaining 66 percent of those who request review of their original State Agency decision. Of the latter group it may be anticipated that more than one-third of those denied will request a hearing. In this event, a further period of six months will elapse between the time their request is received and the date the Hearing Examiner's decision is handed down. For these claimants there is no saving of time, although this winnowing process may result in some reduction in administrative expense in other bureaus within the Social Security Administration.

> It may well be that those who proceed on to a hearing subsequently receive faster processing time due to the additional development of their case at the reconsideration level. However, a more extensively developed case does not necessarily insure a more prompt disposition at the hearing level. The evidence presented may be better documented, but in the development process become more complex, more voluminous and no less contradictory than that passed on in the initial determination proceeding. The net result may be simply to increase the burden on the Hearing Examiner by the development of case aspects extraneous to his decision.
>
> As noted previously, BOASDI submitted the results of its first year's experience with mandatory reconsideration to the Commissioner of Social Security on June 28, 1961. On that date, the total elapsed time for processing an application through the Hearing Examiner level, e.g., date of request for hearing to date of decision, had fallen from an average of 177 days in December 1960 to 92 days in June 1961. No doubt BOASDI was justified in assuming that this reduction was due in part to the fact that an increasing number of applicants were receiving satisfaction at the reconsideration level and, consequently, the smaller number going up the review chain could be handled more expeditiously. Unhappily, this state of affairs did not last, and six months later the average processing time had risen to 171 days in December 1961. In our judgment, the reasons for the wide variance in case processing time at the Hearing Examiner level were due to factors other than the initiation of reconsideration as a mandatory process and, therefore, are not pertinent here. (P. 242-244.)

Reducing Period of Appeal

Some administrators of the program have suggested that reducing the time period of appeal would have a beneficial effect on the Social Security disability program in speeding up the appeals process. In the SSI program the time for a claimant to appeal is 30 days. They point out that an individual has a full 6 months to decide whether to request reconsideration and then another 6 months to decide whether to appeal to an administrative law judge. The law states merely that "any such request with respect to such a decision must be filed within such period after such decision as may be prescribed by regulations of the Secretary, except that the period so prescribed may not be less than 6 months after notice of such decision is mailed to the individual making such request." The possible double 6-month period is the inevitable result of the imposition of the mandatory reconsideration requirement for, as the Social Security Administration puts it, "if the claimant had less than 6 months in which to exercise his right to reconsideration and, failing to exercise this right, was thereby precluded from exercising his right to hearing, he would in effect be deprived of right to a full 6-month period after notice of SSA's decision in which to request a hearing." Thus, the problem of the length of time and mandatory reconsideration are closely linked. Statistics show that about 80 percent of persons appealing both for a reconsideration and a hearing do so by 120 days and about 44 percent have done so within 30 days. (A listing of the elapsed days before filing of appeals is contained in pt. III, p. 246.)

Appeals Council—A Truly Appellate Body

Mention has already been made of the idea of restructuring the Appeals Council to make it a purely appellate body. The Harrison Subcommittee had a number of problems with the Appeals Council. It raised the question (1) whether it should be insulated from Social Security Administration influence in deciding what cases it looks at, a system which has been described as "bureau appeal," and (2) whether it "should, as far as possible, limit itself to a basic review function." The subcommittee report also noted the following colloquy between Congressman Harrison and Social Security Commissioner Mitchell:

> Mr. Harrison. * * * What would you think of transferring the Office of Hearings and Appeals to the Secretary's Office, which would completely divorce it from any control of your agency and protect its independence?

> Mr. **Mitchell**. I would oppose that unless there were some factual demonstration of a need of it. If there were a factual demonstration, then I certainly wouldn't be so bureaucratic as to stand in the way of any such needed reform.
>
> I would strongly recommend, however, Mr. Chairman, that this be one of the topics that we identify for special emphasis in this substantive review process that we are proposing to have made and have that particular problem commented upon by one or more of the outstanding experts in the field, some of whom we have already had assist us in the setting up of our original procedures and who have subsequently reviewed them at one time or another (p. 42).

The "substantive review process that we are proposing to have made" presumably was the Covington and Burling study (the Horsky report). Mr. Horsky saw no particular problem with the legal basis for the Appeals Council in carrying out hearing functions and taking additional evidence but expressed some concern about the legality of "bureau appeal." As a matter of policy, however, Horsky believed that certain changes were required which went to "the basic fairness and propriety of the entire quasi-judicial machinery" of the Social Security system. The report stated that the Appeals Council should be made "a true appellate administrative court" for social security claimants:

> We see no reason, in other words, why Office of Hearing and Appeals cannot be for the Department of Health, Education, and Welfare essentially what the Tax Court is to the Treasury Department. The analogy cannot be pushed too far, because sound administration is peculiarly a matter of adapting forms to situations. Yet in both the Treasury and HEW there are a multitude of issues which arise by reason of the need to apply laws and regulations to varying factual situations in order to resolve disputes as to financial relationships between the government and its citizens. In each case, quasi-judicial determinations are necessary. In each case, the agency which makes these quasi-judicial determinations is subject to review by the Federal courts on the final performance of its functions. In each case, we believe that the agency should have no responsibility other than to determine the facts in each case, and to decide on how the law and the regulations apply to the facts thus determined. (p. 355.)

The Horsky report went on to suggest "that decisions of the Appeals Council should be precedents binding on the Social Security Administration as a whole, unless and until changed by the Appeals Council itself or obsoleted by changes in the law or regulations, and should be published." It declared that the "system by which the public knows of only such Appeals Councils decisions as may pass muster for publication in 'Social Security Rulings,' appears to be at odds with even the present status of the Office of Hearings and Appeals, and inconsistent with the independent quasi-judicial agency we envisage," (P. 358.) (See pt. III for a discussion of social security rulings as to their method of formulation and usefulness and for a fuller discussion of the failure of the present system to communicate policy through an effective precedent system.) Horsky could not understand a policy which permitted the Social Security Administration to disregard an Appeals Council decision in reaching a determination but then have the decision appealed to a hearing examiner who would be bound by the same Appeals Council decision. The report saw the proper functioning.of the system in the following way:

> We recognize, of course, that an Appeals Council insulated from policy discussions with the Bureau and the Commissioner, and whose decisions would be binding on the Social Security Administration as a whole, should be required to accept as valid and binding the regulations issued by the Secretary. Moreover, such an Appeals Council should have in some areas more explicit regulations than now exist. The expanded regulations on disability now in preparation will supply the most obvious need. Once the regulations have been reviewed and supplemented, however, their continuing interpretation, the interpretation of the law in cases which they have not yet covered as well as the determination of the facts in individual cases, would be the responsibility of the Appeals Councils. Ultimate control over the proper functioning of the system would remain in the Secretary,

> acting at the instance of the Commissioner, by virtue of his power to modify or reverse by regulation decisions of Appeal Council which appeared to him inconsistent with the Social Security Act. Even when it is the interpretation of the Act itself which is in question in an area where it has not been interpreted by regulation, the Secretary should be able to change the Appeals Council decision by a subsequent interpreting regulation which thereafter would bind the Appeals Council. There should be no need, in other words, to take any issue to Congress. Claimants, of course, would be protected by their right to challenge Appeals Council decisions—and hence regulations as well—in the courts. (P. 362–363.)

Finally, the Horsky report suggested that "bureau appeal" before the Appeals Council should be on the record. It agreed with "the not unnatural inference of the (Harrison) subcommittee that the practice of informal Bureau recommendations for Appeals Council review amounted to negotiation on questions of substantive procedure and rights affecting the outcome of individual cases." (P. 367.) As to possible criticism that this would make it an "adversary proceeding" the Horsky report stated:

> Finally, we recognize that a practice of formal Bureau appeals would create an overt adversary status for the Bureau before the Appeals Council in such cases, whereas there are now no formal adversary positions taken unless and until the final administrative adjudication is challenged by the claimant in a District Court. We do not regard this as a material disadvantage. As indicated above the "adversary" character of the proceeding is not, in our judgment, a determinative factor in deciding what should or should not be done. Nor do we believe that a formal adversary position in some Appeals Council proceedings would require that the Bureau modify its present practices either in respect to hearings before the Hearing Examiner, or in respect to the consideration of cases before the Appeals Council which reach there on appeals by claimant's or on the Appeals Council's own motion (pp. 373–374).

It might be pointed out in this regard that a modified adversary proceeding might be authorized at the Appeals Council level with the Social Security Administration given the right to appeal ALJ decisions or defend a decision by a written brief or similar document. (This would somewhat resemble what is done under present procedures whereby if there is a Bureau request for the Appeals Council to examine an ALJ's decision, a written request stating the reasons is made part of the record and the claimant given a copy. Similarly, a specification of the issues on appeal might also be appropriate in the interest of fair play to the claimant when the review is instituted by the Appeals Council on its own motion.

It also could be argued that if the Appeals Council is to be purely an appellate body it should be under the "substantial evidence" rule. If further evidence is required there should be remand to the ALJ's for fact-finding at the hearing level. This latter procedure would meet some objections which were voiced during the Harrison study and which are still being raised.[5]

If the Appeals Council were a true appellate body, it might have a substantial effect on disability litigation in the courts. It might affect the courts' propensity to disregard the "substantial evidence" rule and evaluate the evidence "de novo." If the district courts believed that a claim had already gone through one truly independent appellate process they would be much more likely to honor the "substantial evidence" rule. More stringent application of the rule should eventually result in fewer appeals to the Federal Judiciary. Such a change in the Appeals Council would also make possible another alternative approach to the stricter implementation of the substantial evidence, i.e., an appeal directly to the Court of Appeals, as in N.L.R.B. cases, which would emphasize the necessity to follow "substantial evidence" rule. The G.W. Law group dealt at length with the court's application, or lack of application, of the "substantial evidence" rule. It stated:

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[5] The recent *Betty Brock* case dealt with the right of the Appeals Council to review new evidence and issue its own findings of fact. The issue was whether the inability of the claimant, who was from California, to attend the Appeals Council session in Virginia had prejudiced the proceeding where demeanor and credibility of the claimant was a major ingredient. The case was dismissed without judicial findings on these issues.

> The magnitude of the Social Security disability insurance benefits program and its great reliance upon medical evidence may indicate the need for a redefinition of the "substantial evidence" rule to be applied in the judicial review of Social Security Administration findings. It is even possible that the generalist-lawyers who become district judges are presumptively incapable of intelligently reviewing disability determinations. If so, neither the Social Security Administration nor the Courts themselves, but the Congress is the proper body to address; and perhaps an expert judicial body such as the Tax Court or the Court of Customs and Patent Appeals will be constituted by statute. (Pt. II, pp. 7–27.)

Problems relating to the application of the substantial evidence rule are discussed further in section H of this part.

REMAND AFTER JUDICIAL REVIEW IS SOUGHT

Section 205(g) of the Social Security Act states:

> The court shall, on motion of the Secretary made before he files his answer, remand the case to the Secretary for further action by the Secretary, and may, at any time, on good cause shown, order additional evidence to be taken before the Secretary, and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or his decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based.

In 1960 the Harrison Subcommittee noted that the Secretary of HEW had requested remand of about 27 percent of the civil cases filed. The report stated that, although there may be valid reasons for remand to better develop cases and to allow claimants benefits more expeditiously, the Department may also be just buttressing them for court scrutiny. The subcommittee concluded that it was:

> * * * not convinced that this practice is wholly fair to the claimants involved. We believe that the full committee may wish to consider the advantages of making remand on request of the Secretary discretionary with the court, on the same basis as if requested by the claimant; that is, where there is some showing that there is new evidence which is material, and that there is good cause for the failure to incorporate it in the record prior to court review (p. 41).

The Horsky report also dealt with the remand question; it stated:

> It would be inappropriate to say more than that we share the Subcommittee's doubts as to the wisdom of granting to the Secretary the absolute right of remand before answer. (By 1960 34 percent of the court cases had been remanded. Sixty-two percent of these were still pending as of October 1960.)
>
> * * * we can fully appreciate the difficulties which OHA (Office of Hearings and Appeals) has in connection with the remanded case. * * * the difficulties of the claimant are equally great. He has presented his claim through the many steps of the administrative process, fully exhausted his administrative remedies, sought judicial review, and without any right to object has been returned to the administrative agency. No regulations advise him of what then happens to his claim, and in practice it disappears for an extended period of time * * *.

The report further stated:

> We believe improvements should be made in two ways. First, remand procedures should be spelled out fully in the published regulations of the Department. The present almost haphazard way in which a claimant is accorded the right to know and participate in what is going on after remand is manifestly unfair.

> Second, remands should be given an absolute priority over all other matters at the Office of Hearings and Appeals with a view to expedition in their handling (p. 459 et seq).

In fiscal 1973, there were approximately 850 cases remanded from the district courts to the Bureau of Hearings and Appeals. About half of these were on motion of the Secretary. The following is an excerpt from a Bureau of Hearings and Appeals' analysis of the court remands on motion of the Secretary for the disability cases in the second calendar quarter of 1973:

> Of the 96 cases remanded on motion of the Secretary, 86 involved claims for disability benefits; 8 involved claims for retirement and survivors benefits; and 2 involved claims for health insurance benefits.
>
> (*1*) *Disability cases*
>
> (*a*) *Kerner-type development.*—The claimants (in 11 cases) were found incapable, by reason of their impairments from engaging in their former or prior work, yet there was an absence of any vocational input. Request for remand in such cases was consistent with Appeals Council policy that, regardless of the jurisdiction, live vocational testimony is required.
>
> (*b*) *Remands for medical development.*—Fifty-five cases were remanded, because the Appeals Council felt *that the medical evidence of record was insufficient to render the case defensible in court.* In the vast majority of cases, one or more current consultative examinations were to be undertaken. The remaining cases were remanded for the purpose of either obtaining additional reports from existing sources, such as VA, Workmen's Compensation Commissions, and other public and private hospitals or physicians; while others were remanded either for additional documentary evidence and/or testimony by a medical advisor. [Emphasis added.]
>
> (*c*) *To consider newly submitted evidence.*—In four cases remand was requested after the Appeals Council had received additional medical evidence not previously of record; while in one case remand was requested in order to develop work activity upon receipt of earnings information from the Bureau of Data Processing.
>
> (*d*) *Remands requested for the purpose of reversing prior administrative action.*—Twelve cases, including one for childhood disability benefits, fell in this category.
>
> (*e*) *Remands requested for other purposes.*—One case was remanded for the purpose of obtaining additional evidence of earnings, to determine if she was insured as of the alleged dates of disability. In two other cases, the Appeal Council obtained remand for the purpose of issuing decision which would adjudicate the question of disability during periods not dealt with in the prior administrative decisions.

From the foregoing analysis it does not appear altogether clear that the problems that the Harrison Subcommittee and the Horsky report had with this procedure have been resolved. It should also be noted that in fiscal 1973, the median time for disposal of court remands was 222 days.

USE OF PARALEGAL AND PARAJUDICIAL PERSONNEL

A number of separate but related developments have occurred with respect to the use of paralegal and parajudicial personnel in the courts and the administering agencies.

By the courts

Some U.S. District Courts are using magistrates to assist them with their Social Security case workload. The Federal magistrate system, which has been in operation for 2 years nationwide, resulted in the filing of reports and recommendations in 284 Social Security Act cases in 25 districts in fiscal 1973. The magistrates replace the U.S. Commissioners who previously exercised judicial functions in dealing with minor criminal offenses and other duties. The Federal Magistrates Act provides in broad terms that district courts, by local rule, may assign to magistrates "such additional duties as are not inconsistent with the Constitution and laws of the United States" and gives as nonexclusive examples, duties as a special master and assistance to judges in pretrial and discovery proceedings and in deciding on requests for posttrial relief (28 U.S.C., sec. 636(b)). The 1973 Report of the Administrative Office of the U.S. Courts notes that there is some disagreement among circuits as to the appropriateness of delegating such authority in Social Security cases:

> In *Ingram* v. *Richardson*, 471 F. 2d 1268 (6th Cir., 1972), the United States Court of Appeals for the Sixth Circuit ruled sua sponte that it was error for a district judge to refer an appeal from a decision of the Secretary of Health, Education and Welfare denying Social Security benefits to a magistrate for a report and recommended decision. No written order of reference to the magistrate appeared in the file, and a copy of the magistrate's report, according to counsel, was the appellant's only notice of the reference. The court cited the provisions of Rule 53(b) of the Federal Rules of Civil Procedure and in effect treated the reference to the magistrate as an improper delegation of judicial functions to a special master.
>
> Although the question was not specifically in issue, the United States Court of Appeals for the Fifth Circuit did not appear to be troubled by the reference of a Social Security case to a magistrate for report and recommendation. In *Dewrell* v. *Weinberger*, No. 73–1058 (5th Cir. 1973), the district court had relied upon the written recommendations of a magistrate in affirming the administrative decision of the Secretary of Health, Education and Welfare. The Court of Appeals affirmed without comment. Accord, *Harbold* v. *Richardson*, 464 F.2d 1063 (3rd Cir. 1972) (sec. VI, pp 12–13).

Attention is called to *Murphy* v. *Weinberger*, U.S. District Court, District of Connecticut, Civ. No. B–613, decided in March of this year, where the Court upheld the use of a magistrate in a Social Security case distinguishing his functions from those of a special master under rule 53(b) which calls for the Court's acceptance of the findings of fact "unless clearly erroneous." The Court rejected the *Ingram* case as applied to its local practice and stated that in Social Security disability cases "the magistrate's written discussion and opinion of the merits of a typical motion for summary judgment are but a recommended ruling as a matter of law fully open to scrutiny and acceptance or rejection by the judge on the same documentary record of fact as that before the magistrate." The Court noted that it has been "advised that—by specific direction of the Justice Department—government counsel will object hereafter to any similar referrals (to magistrates) to any actions for review under 42 U.S.C. section 205(g)." The Court stated "at bottom, the Justice Department is evidently voicing a constitutional concern over excessive delegation of authority to magistrates amounting to an abdication of the judges' article III powers and responsibilities. That apprehension is without basis in the District of Connecticut's practices."

The use of magistrates raises some interesting questions in the district court treatment of disability cases. It might be argued in the affirmative that it would assist the more hard pressed courts to meet their workload demands. On the other hand, the use of such magistrates would appear to be primarily in areas where the court is examining the record and the weight of the evidence. This is true, for instance, in the *Murphy* case just cited. Whether this might have the effect of increasing "de novo" proceedings and more circumvention of the "substantial evidence" rule by the courts is worthy of some consideration.

By Administrative Law Judges

The Administrative Law Judges (and the former hearing examiners) have long had hearing assistants as well as secretaries to perform work necessary to save their time. In some situations, one judge will have more than one hearing assistant.

The increasing caseload led the Bureau of Hearings and Appeals to investigate other ways of using paralegal personnel. For instance, a qualified analyst may be assigned to an Administrative Law Judge to work under the judge's direct supervision on the preparation of decisions already determined by the judge, the highlighting of issues in cases, the preparation of letters seeking developmental information needed to complete the record, and other types of paralegal duties usually performed by law clerks for judges.

In addition, the concept of the development center has been implemented by the establishment of several centers in which cases are developed and made ready for the attention of the Administrative Law Judge. This includes the checking of the record to make sure that every paper is in its proper place and that all the available information is in the file. These centers were initially experimental for the cases in the Black Lung program and the Health Insurance program but they are being expanded for use in the general program of Social Security and Supplemental Security benefits.

By the Appeals Council

Hearings and Appeals Analysts in the Bureau of Hearings and Appeals perform staff work for the Appeals Council in connection with the disposition of cases which are pending on appeal. The analysts make substantive recommendations to the Appeals Council as to the course of action which should be taken in claims for benefits under the Social Security Act and the Federal Coal Mine Health and Safety Act (Black Lung) and prepare decisions and orders at the direction of the Council.

The analysts who work in the Division of Appeals Operations generally have a background in the various benefit programs administered by the Social Security Administration, based on years of work experience in other bureaus of SSA. Some individuals directly out of college are also hired for this work.

In recruiting analysts for the Division of Appeals Operations, BHA would prefer law school graduates, but in recent years, it has not been able to hire a significant number. The Bureau believes, however, that a legal education is not a prerequisite to successful performance on the job. New analysts undergo an intensive formal "in-house" training program, which includes instruction in the preparation of case analyses and decision writing. In addition, they receive on-the-job training from supervisors and senior analysts who offer advice and assistance and review written work products. Although no definitive study has been done to compare the performance of the nonlawyers with that of attorneys, BHA is convinced that such nonlawyers are capable of preparing sound recommendations as to the proper disposition of cases and drafting decisions which demand a high degree of technical excellence.

E. STANDARDS AND DEFINITION OF DISABILITY: WHO SETS THEM—THE CONGRESS, THE SOCIAL SECURITY ADMINISTRATION, OR THE COURTS?

The definition of disability is phrased in broad language and the legislative reports which accompanied the enactment of the definition in 1954 and 1956 supplied few guidelines for its interpretation. The Harrison Subcommittee believed that the Social Security Administration was following the "pragmatic approach advocated by the Advisory Council on Social Security to the Senate Committee on Finance (1949)—a legislative definition written in rather broad terms to be implemented by more specific administrative regulations on the basis of operational experience."

The subcommittee went on to say that at that time (1960) "the development of operational 'case law' has been going on for some time, but very little of it, thus far, has been made public in the form of regulations." The subcommittee believed that lack of precedent materials in the form of regulations or agency rulings was leaving a vacuum and "the distinct possibility exists that if the situation remains unchanged the courts rather than the Department or Congress will set the standards." Some of these concerns the subcommittee stated might well affect the actuarial status of the disability program

It appears that experience subsequent to 1960 bears out the fears of the subcommittee. The failure of the Social Security Administration to promulgate precedent materials, particularly regulations on the nonmedical and vocational factors in disability evaluation, has caused many varied interpretations of the law and, to a large degree, policy setting by judicial interpretation. Although we lack data which shows a direct causal relationship between these developments and the chronic actuarial insufficiencies in the disability fund, the Congress has been presented with substantial adverse cost experiences in 1965, 1967, 1972, 1973, and this year. This section discusses some of the judicially derived developments in the nonmedical factors area which have had major impact on the substance of the disability insurance program.

Under past and existing practice, even though a claimant's impairments do not reach the presumptive level of severity required by the medical standards, he still could qualify for benefits by the application of the so-called nonmedical standards in the evaluation process. At the time of the Harrison study, the regulations stated merely that "consideration is also given to such other factors as the individual's education, training, and work experience" in evaluating whether these elements together with his medical impairment make a claimant "unable to engage in any substantial gainful activity." The Social Security Administration stated at that time that 10 percent of the allowances were based on these factors and they were involved in a high proportion of the cases which were administratively and judicially appealed. The 1960 Harrison report stated:

> The subcommittee recognizes the difficulty of developing and enunciating specific criteria for the weight to be given nonmedical factors in the evaluation of disability and the extreme sensitivity of this area. But the subcommittee believes that the time has come, if it is not well overdue, to make a determined effort to develop and refine these criteria and make them available to the evaluators and to the public in the form of published regulations (p. 18).

Immediately following Harrison[1] there were a number of relatively minor amendments of the regulations which reflected certain materials in the confidential State disability insurance manual—age was mentioned as a criteria and a presumption of disability was provided for individuals with marginal education and long work experience at unskilled physical labor who could no longer work at such labor. After August 1960, and for the next 7 years, however, there were no substantive change or elaboration of the nonmedical factors in the regulations or in the Social Security Rulings. The latter were cited as an answer to the subcommittee's call for the publishing of more precedent materials.

KERNER DECISION—VOCATIONAL FACTORS IN DISABILITY

Later in the year of the Harrison report, Judge Friendly of the Court of Appeals for the Second Circuit wrote an opinion[2] which is generally acknowledged to have had a major impact on the definition of disability and its administration by the Social Security Administration. Courts at that time varied greatly in their opinions as to how it was to be shown that a claimant was "unable to engage in substantial activity" in terms of job availability. Some courts were verging on an occupational definition of disability, while others were saying that the claimant must be able to engage in work that was "commensurate with his education, training, and experience." The Harrison Subcommittee specifically rejected these two approaches and stated "that in order to assure uniform interpretation by the courts, as well as to afford an opportunity for effective congressional appraisal of the overall program, the present interpretation of the Department should be spelled out by regulation at the earliest opportunity." In the period 1960–61 there was also a growing number of decisions that indicated that once the claimant had met the burden of proving his inability to do his old job and his lack of any obvious skills for other jobs, it was incumbent on the Government to show that he was actually—not theoretically—capable of some type of work. (This was a specific area of concern for which the Subcommittee had asked HEW for regulatory elaboration.) On the other hand, other courts were making decisions on the basis of "burden of proof" or on the "substantial evidence rule" which upheld hearings examiners such as the one in the *Kerner* case who had said that the claimant's impairments were such that it appeared that he could engage in "some form of light or part-time sedentary work * * *. The fact that work which would be within his capacity may not be readily obtainable, cannot be substituted as standards of disability for the strict standards set forth in the act, namely, complete inability to do any substantial gainful work."

In this context, the circuit court in *Kerner* stated that it could neither affirm or deny the decision not to pay benefits where there appeared to be no substantial vocational evidence that would enable the Secretary to make a reasoned determination that the applicant was unable to engage in substantial gainful activity. Judge Friendly acknowledged that the applicant had the ultimate burden of proof, but he believed that the court was not bound to sustain a denial of disability where the applicant had raised "a serious question" and the evidence affords no sufficient basis for the Secretary's negative answer. The court concluded that the Secretary had offered nothing save speculation to warrant a finding that Kerner could perform light or sedentary work. Judge Friendly declared that a disability determination "requires resolution of two issues—(1) *what can applicant do*, and (2) *what employment opportunities are there for a man who can do only what applicant can do*. Mere theoretical ability to engage in substantial gainful activity is not enough if no reasonable opportunity for this is available." [Emphasis added.] Finding the evidence insufficient on both issues, the court remanded the case to the Secretary.[3]

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[1] At the conclusion of the Harrison hearings, Social Security Commissioner Mitchell stated: "During the course of the hearings, there was testimony that the regulations under which the disability process is conducted should be made more complete. The subcommittee indicated that it would be desirable to provide more comprehensive regulations as an aid not only to informing the disabled of their rights under the program, but also in providing further assurance that the States, the Bureau of Old-Age and Survivors Insurance, and the Office of Hearings and Appeals are operating under a common understanding. We are all in agreement on this and we are now considering the extent to which the policies which are used in determining disability can be dealt with in more detail in the regulations. We will see to it that expanded regulations are published" (pp. 956, 957).

[2] *Kerner* v. *Flemming* (1960), 283 F. 2d, 916.

There was no appeal of *Kerner* by the Government[4] nor was there any change in the regulation. But during the period November 1960 through December 1962, 76 cases were remanded by the courts to the Secretary on the basis of *Kerner*—67 by district courts and 9 by courts of appeals.

Faced with the remands and apparently a Government decision not to appeal the *Kerner* doctrine, the Appeals Council had to take steps to meet the vocational evidence problem. This is apparent from a decision of the ninth circuit in 1961 (*Graham* v. *Ribicoff*, 295 F. 2d, 391), whereby a finding that the claimant was capable of engaging in substantial gainful activity was documented by the Appeals Council with Government studies which, in the words of the court "indicate that many types of jobs are capably filled by persons with back and limb impairments of this kind, among which were numerous jobs which require little or no training or educational background."

The second circuit in 1962 in *Rinaldi* v. *Ribicoff* (305 F. 2d, 548), similarly approved the use of such studies to show job availability for persons with similar impairments. The Appeals Council in these cases had interpreted the second issue of the *Kerner* doctrine—what employment opportunities are there for a man who can do only what the claimant can do?—as requiring only a finding of whether or not there existed in our economy any types of jobs which could be performed by an individual such as the claimant but not requiring the Government to point to specific job vacancies which might be available. Although this approach was not altogether settled, it generally seems to pass judicial muster.

By 1963 the *Kerner* doctrine seems to have started filtering *backwards* into the disability determination system. In that year the hearing examiners started using vocational consultants as expert witnesses. The *Rinaldi* and *Kerner* cases were printed in the Social Security Rulings without comment and interpretative materials relating to nonmedical factors were circulated to the State agencies. For example, OASI Disability Insurance Letter No. III-3 (Sept. 20, 1963) stated:

> In those cases in which either the impairments are so severe as to make the claimant unable to do the work he did before, or he has tried to work with his impairment and it has been found that he is medically unable to keep up the work, if there is nothing to show affirmatively what type of work he can do, the courts require evidence on and resolution of these issues:
>
> 1. What can the applicant do, and
> 2. What employment opportunities are there for a man who can do only what the applicant can do.
>
> The issue of what the applicant can "do" involves three distinct considerations: (1) To what extent can he perform work-related physical and mental activities; (2) what work is he qualified to do in view of his age, education, and vocational background; (3) what jobs are within both his vocational abilities and functional capacity. This is what he can "do".

Although it would seem clear that the Social Security Administration had accepted *Kerner*, the regulations remained unaltered, reflecting none of the changes in burden of proof or the use of vocational evidence which *Kerner* had brought into effect.

NATIONAL ECONOMY TEST

In applying the *Kerner* doctrine of the availability of employment opportunities, the question arose as to the geographic area to which it should apply. In 1961 the answer was varied. The fifth circuit had a number of cases following *Butler* v. *Flemming* (288 F. 2d, 591), which said it should be available in the

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[3] Over 2 years later, in December 1962 the Appeals Council again denied Kerner benefits. In a decision in 1965 the 2d Circuit of Appeals finally ended Mr. Kerner's unsuccessful 9-year quest for benefits.

[4] An appeal was requested by the Department of Health, Education, and Welfare, but it was turned down by the Department of Justice.

"general area where the claimant lives." Other courts used the phrase "in the local labor market in which he resides," "in the vicinity of plaintiff's home" or "in or near plaintiff's farm." These were not the tests the Social Security Administration had in mind. As early as 1954 the following policy had been enunciated in an internal memorandum:

> Certain vocational factors which are taken into account in some programs will not be acceptable to overcome the presumption of "no disability." Specifically, the nonexistence in the individual's locality of some jobs he can do will be given no weight in determining his capacity for substantial gainful activity. The general existence of jobs in the American economy and the physical demands of those jobs as generally recognized in the American labor market will be the criteria on which the standards will be built.[5]

Such policy was not spelled out in the regulations, however. At the time of the Harrison hearings a pamphlet had been issued (1958) which contained the the following general observation which has some relevance to the SSA position on the issue of job availability:

> A person may become unemployed or remain unemployed for a number of reasons other than disability: individual employer hiring practices, technological changes in industry in which the applicant has been employed, local or cyclical business or economic conditions, and many others. The disability provisions are intended to benefit only those persons who are not working because of incapacity, and not those unemployed because of these other factors.[6]

Similar language was incorporated into the regulation in August, 1960.

During the period 1964–67 the state of the case-law in this area became increasingly confused. In 1966 the Administration printed in the Social Security Rulings decisions of the 4th and 6th circuits[7] with the notation that they did not "acquiesce in the decisions." On the other hand, the Administration did not clearly spell out what its policy was in the Rulings, stating merely:

> * * * where the Administration has found that he is no longer able to do his former work but can do other types of existing work, it is not necessary that the Administration establish that such work exists in the immediate locality of his residence or that he could, if he applied for work, secure employment.

Moreover, the Government did not appeal the cases nor did the Administration amend the regulations. This was true even though the National Economy test had been articulated at considerable length in the confidential Disability Insurance Letter of September 1963. This letter stated in part:

> Job availability is established when there is evidence that there are jobs in the economy the applicant can do. This means that applicants are expected to have sufficient mobility to avail themselves of jobs that are generally prevalent in our economy, though mobility limitations that are impairment-related may be considered in assessing job availability. Thus, the incidence of jobs in the State, region or nation which the applicant can do should be cited as evidence of job availability, and the fact that such labor may not be in demand in a particular city or town could not rebut the finding of employment availability.

Included in the appendix to this section is a more detailed explanation of this policy which was also contained in the Disability Insurance Letter together with two illustrative cases on how these guidelines would be applied to specific cases.

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[5] Memorandum dated Nov. 4, 1954, from Director of BOASI to Social Security Commissioner, "Major Policy Assumptions in Disability Fields."

[6] "Disability Fact Book," Subcommittee of the Administration of the Social Security Laws, Committee on Ways and Means, p. 21.

[7] In *Cyrius* v. *Cellebrezze* (1965) 341 F. 2d 192 (4th Cir.), the Court stated that a serious defect in the Secretary's finding was "the total absence of proof that jobs exist in the local economy" which the claimant was capable of performing. In *Massey* v. *Cellebrezze* (1965) 345 F. 2d 146 (6th Cir.) the Court said that job "opportunities available to a person who can do only what the claimant can do * * *, refer to job opportunities *in the general area in which the plaintiff lives.*" The Department of Justice turned down HEW's request to appeal this case to the Supreme Court. No appeal was requested by HEW in *Cyrius*. (Printed in "Social Security Rulings, Cumulative Bulletin" 1966, pp. 103–122.)

Developing contemporaneously with these developments was a substantial actuarial deficit in the Disability Insurance Trust Fund which was remedied by the Congress by a reallocation of the payroll tax in the 1965 amendments. When legislation was being considered in 1967, there was an even more serious deficiency but still the Administration did not suggest any substantive change in the disability definition. The Social Security Administration maintained that the actuarial deficiency was due to better communication to claimants of their rights under the program, better development of evidence of disability, and more effective ways of assessing the total impact of an individual's impairment of his ability to work. (These general statements could, of course, refer to *Kerner* and its subsequent administrative development but this is not clear from the material.) Such statements did not satisfy the Committee on Ways and Means which had also heard about court cases and it requested a memorandum explaining how judicial action was affecting the program. The reply of the Social Security Administration was inserted into the committee report. It stated that in some jurisdictions court decisions showed:

> (1) An increasing tendency to put the burden of proof on the Government to identify jobs for which the individual might have a reasonable opportunity to be hired, rather than ascertaining whether jobs exist in the economy which he can do. Claims are sometimes allowed by the courts where the reason a claimant has not been able to get a job is that employers having jobs he can do, prefer to avoid what they view as a risk in hiring a person having an impairment even though the impairment is not such as to render the person incapable of doing the job available.
>
> (2) A narrowing of the geographic area in which the jobs the person can do must exist, by reversing the Department's denial in cases in which it has not been shown that jobs the claimant can do exist within a reasonable commuting distance of his home, rather than in the economy in general.[8]

To remedy this situation the Committee recommended putting directly in the statute language similar to that which appeared in the 1963 Disability Insurance letter and this was enacted into law by the 1967 amendments:

> An individual * * * shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country (sec. 223(d)(2)(A)).[9]

Eventually this language appeared practically verbatim in the regulations.

In summary, the Social Security Administration, despite the very specific urging of the Harrison Subcommittee, did not on its own initiative amplify the definition of disability by regulation. As a consequence, the courts acted to fill

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[8] H. Rept. 544, 90th Cong., p. 29.

[9] It should be noted that there is a difference between the Disability Insurance letter and the statute: the letter states the test as "whether the jobs the applicant can do exist in reasonable numbers in the State or region in which he lives or exist in reasonable numbers and distribution in our national economy." The statute states "work which exists in significant numbers either in the region where such individual lives or several regions of the country." Disability Insurance Letter III-8 issued Jan. 8, 1968 immediately after the 1967 Amendments stated:

> This added language is consistent with present Regulations and policy, and State agencies will continue to follow existing evaluation policies and procedures including those which pertain to documenting the existence in the economy of jobs in which the individual can engage. The addition of the definition of work which exists in the national economy as "work which exists in significant numbers either in the region where such individual lives or in several regions of the country" represents new terminology but is consistent with existing policies on documenting "job availability."

out the law as illustrated by the *Kerner* case. In respect to the national economy doctrine, it can reasonably be argued that Congress was forced to ratify by legislation confidential Social Security Administration policy of long standing because of the Social Security Administration's failure to promulgate proper guidelines in the form of regulations.[10] It further can be argued that the result has been lack of uniform application of standards and, perhaps, adverse disability experience which has contributed to the actuarial imbalances in the trust fund. In part I of this report there is a recommendation that a task force should be appointed, made up of key personnel of the Social Security Administration and the State Agencies to determine whether problems arising out of the application of the definition of disability can be resolved by clarification or amplification of the regulations. For the sake of uniform application of standards throughout all segments of the disability system and a rational manner of submitting substantive issues to the Congress if there is conflict between the administrators and the courts, the Social Security Administration should spell out a detailed definition of disability in the regulations including a clear statement of just how the burden of proof will be distributed between the claimant and the Government.[11] If this cannot be done by modifying the regulations a more detailed statement of the definition and burden of proof in the statute may be necessary.

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[10] Dixon states that: "The key problem area was perceived [by the GW study] to be the standard of disability itself, which, 'in the absence of summary regulations,' was by default 'consigned to the courts.' Other problem areas, all resulting from the imprecision of the legal standard, included the burden of proof, the courts' apparent distrust of the SSA administrative process, and the meaninglessness of the substantial evidence rule." (Dixon, p. 94)

[11] Dixon believes that there is language in the Disability Insurance State Manual which creates a presumption of "when in doubt, deny" in applying the nonmedical factors by using such phraeseology as "in a predominant number of cases adjudicated under the section 404.1502(b), the applicant will be found to have residual and vocational ability to meet job requirements." This position, he states, is not necessarily at odds with congressional intent. William D. Popkin, a University of Indiana law professor, in the article "Effectiveness of the Social Security Review System in Disability Cases" (Administrative Law Review, winter, 1974) states:

> The State agencies are able to dispose of approximately 94 percent of the cases, either by allowing a little less than one-half of the claims on grounds other than economic disability, or by allowing a little less than one-half of the claims on technical grounds or because the claimant was not economically disabled. The State agency is instructed by the Federal Bureau of Disability Insurance to presume that a claimant in not economically disabled. Of the remaining 6 percent of the cases (around 60,000) which are reviewed by an administrative law judge (ALJ), almost half are reversed (pp. 81, 82).

APPENDIX

[Excerpt from OASI Disability Insurance Letter No. III-3, Sept. 20, 1963]

AVAILABILITY OF WORK APPLICANT CAN DO

The test of job availability is whether the jobs the applicant can do exist in reasonable numbers in the State or region in which he lives or exist in reasonable numbers and distribution in our national economy. The application of this test requires some background on the distribution and kinds of work in our economy.

As of 1960, approximately 53 million workers earned their living in one of the following 8 major industries: manufacturing, trade, government, service, transportation, construction, real estate, and mining. Over two-fifths of the workers in these industries in 1960 (22.8 million) were employed in three industries: manufacturing, transportation-public utilities, and construction. These three industries are prevalent throughout the Nation; and in each of these three industries, more than 60 percent of the total work force is composed of "blue collar" jobs. Three major groups of workers comprise the blue collar workers: skilled, semiskilled, and unskilled. Semiskilled workers are the most numerous of all major occupational groups; in 1960 they totaled about 12 million and were 18 percent of the total work force. Approximately 3.7 million unskilled workers were employed in 1960. Skills bear no necessary relationship to the physical demands of jobs. Thus, skilled, semiskilled, and unskilled work may range from sedentary to very heavy work.

This general survey of the kinds and distribution of work in our economy provides a framework within which the concept of job availability may be applied. The economy is supple and highly diversified. By virtue of its diversity, thousands of jubs are duplicated in every sector of our Nation. This fact makes job availability a reality for many individuals in our applicant population who must make a vocational accommodation to an impairment. Further, the variety and distribution of jobs in our economy is such that in most instances where the applicant is found able to do jobs, these jobs will not only be prevalent throughout the economy but will generally be found in the applicant's community, State or region. Background source material, such as the Occupational Outlook Handbook, published by the U.S. Department of Labor (see below, Section IVD), support this conclusion. The fact that jobs the applicant can do exist in the community, State or region in which he lives, makes it possible to provide a personalized decision which is more meaningful to the applicant.

The distinction between work the applicant can do and job availability is an important one and should be maintained in evaluating disability. The objective in posing the two issues is not to determine if we can find a job for the applicant. Rather, it is to determine if the work the applicant can do is available in the economy. An affirmative finding would mean that the applicant is not under a disability. (See Case Example 1 and 2 cited above, which are attached.)

The general principles discussed in Section III of this DIL have widespread applicability and their implementation will do much to provide consistent and sound decisions. However, the consistency and soundness of decisions will depend as much on documentation as on evaluation technique.

CASE EXAMPLES

EXAMPLE 1

Generally, an applicant will be found able to do jobs which he has performed in the past and which he can still do functionally.

Facts

The applicant is 56 years old and has a fifth grade education. She states that she is unable to work at her usual job as laundromat attendant due to back and leg pain which is brought on when she stands for long periods and when she bends to pick up bundles of laundry. Her duties in the laundry involve placing bundles of laundry in the machines (15 machines), removing wet laundry, ironing articles of clothing, packaging laundry. She has to be on her feet most of the working day, except for brief intervals, and the work requires repeated lifting, bending and stooping. Bundles of laundry weigh as much as 30 pounds. She has done laundry work throughout most of her working life (20 years); however, prior to her most recent job in the laundromat she worked as a sewing machine operator in a garment factory for 5 years. She states she performed this work satisfactorily, but that 3 years before onset she returned to the laundromat work. She states that she terminated work in the garment factory because her husband obtained a job in another city; they changed their residence to an area which is 40 miles from the garment factory. As a sewing machine operator, she had experience in several sewing operations: sewing collars, shoulder seams, and sleeves. These jobs involved sitting, handling clothing material, and operating the sewing machine.

She is able to read and write and answer questions about her application. Daily activities include light housekeeping chores and sewing at home on her own sewing machine.

Medical evidence establishes that the applicant has a musculoskeletal impairment which is expected to be of long-continued and indefinite duration and which significantly interferes with her capacity for prolonged standing, lifting weights in excess of 15 pounds, and more than occasional bending. She is able to sit and use her arms and hands without restrictions, and there is no impairment of vision.

Discussion

It is shown that the applicant's customary work as a laundry attendant involved prolonged standing, repeated bending, and lifting of weights up to 30 pounds; and it is also shown, by adequate and competent medical evidence, that the applicant's impairment prevents her from carrying out tasks involving these physical demands. It must therefore be concluded that the applicant's impairment prevents her from doing her customary work. With respect to other work which the claimant is functionally and vocationally able to do, it is shown that 3 years prior to onset the applicant performed the duties of a sewing machine operator for 5 years. This work involves sitting, hand-eye coordination, handling, and some reaching. It does not require prolonged standing or walking. Functionally, the medical evidence establishes that she has the residual capacity to meet the demands of this work. It is recognized that the applicant is now 56 years of age; however, the applicant's advanced age would not be a bar to return to work in the apparel industry. In this connection, the Occupational Outlook Handbook notes that these jobs are performed while seated and require little physical exertion. The handbook further notes that many workers in their fifties and sixties are among the industry's most skilled and productive workers; that most of the opportunities for employment will be in the sewing machine operator jobs because this is the largest occupational group in the industry; and that the nature of the jobs in this industry will remain about the same since it is much less mechanized than most manufacturing industries. Thus, the applicant has the residual function to perform the duties of a sewing machine operator; she is qualified by virtue of her work experience to perform this work and there are many persons of the applicant's age who are performing this work in the garment industry. It is noted that the applicant resides within 40 miles of several garment factories. Thus it is shown that the work the applicant can do is not only available in the economy but is in fact available in an adjoining community.

Conclusion

A denial is appropriate, since there are jobs in the economy which she can still do functionally and vocationally.

EXAMPLE 2

Generally, the applicant who retains the physical ability to do a wide range of light work, who is not of advanced age (ordinarily under 55 years of age), and is able to communicate, read and write on an elementary level, may be considered to still be in the competitive labor market for light unskilled work, despite the absence of special experience or skills.

Facts:

Claimant is 48 years old, has a sixth grade education. He is able to read, write, do simple arithemtic, and answer detailed questions about his vocational life, earnings, and other information pertinent to his application for disability benefits. Daily activities include helping his wife with some of the light housekeeping duties. He follows sports activities in the newspaper and likes to go fishing. The medical evidence, including history, clinical, and laboratory findings, diagnosis and functional and therapeutic assessment establishes that he has Arteriosclerotic Heart Disease IIB, with angina on strenuous exertion; that he can climb a flight of stairs; walk on a level for 1 mile without discomfort; lift up to 20 pounds occasionally; carry up to 10 pounds frequently.

The claimant has always worked as an arduous unskilled laborer on railroad tracks. In this work, over the years, he performed a variety of tasks: carried and distributed rails across ties; spiked rails to ties with a hammer; bolted sections of rails together at joints with long-handled wrenches; tore up rails and ties; cleaned switches and lubricated switch points; inspected tracks for loose bolts; cleared materials from tracks with a shovel. His work required lifting heavy weights, frequently in excess of 50 pounds, and shoveling dirt and hammering ties which required considerable exertion.

Discussion

The claimant's contention that he cannot perform his former job which required arduous physical labor is supported by the medical evidence. On the other hand, it is clear from this evidence that he has the residual functional capacity to meet the physical demands of a wide range of light work. The younger an individual is, the more clearly other circumstances must be quite adverse. In view of his work experience, which was entirely confined to unskilled work, and his marginal education, it is reasonable to find he is confined to unskilled work, in which special experience or more than elementary abilities in reading, writing, and arithmetic are not required. Thus the claimant is functionally and vocationally able to do light, unskilled work. Light unskilled work is one of the largest segments of work in our economy in terms of the number of persons so employed and the wide variety of jobs so classified. While persons of this applicant's age, background, and qualifications may have difficulty securing work in some sections of the country, there are many individuals in this age group with a similar background who are regularly employed in light unskilled work. This claimant is not of advanced age, and it is therefore reasonable to find that he is able to do light unskilled work in competition with others. The work in which he has engaged involved manual and manipulative work. There are many light unskilled jobs involving similar characteristics. A few such jobs are wrapping machine operator, tool cleaner, sheet metal trimmer, wire stripper. These are standard occupations, prevalent throughout the national economy. As a matter of background information, it is noted that the Estimates of Worker Trait Requirements for 4,000 Jobs shows that the above jobs are classified as light work and that the maximum capabilities to immediately function in these jobs in terms of reasoning, mathematical and language development are as follows:

1. apply common sense understanding to carry out spoken or written one- or two-step instructions, deal with standardized situations with only one or two very occasional variables;
2. perform simple adding and subtracting; and
3. comprehension and expression of a level to sign name and understand what is being signed—read simple materials such as lists, addresses, and warnings.

Individuals with a marginal education are frequently able to meet these requirements, and the evidence in this case which shows that this applicant can read, write, and do simple arithmetic establishes his ability to meet the requirements.

Conclusion

A denial is appropriate since there are many light unskilled jobs in the economy which the claimant can do functionally and vocationally.

F. STATUS OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM UNDER THE ADMINISTRATIVE PROCEDURE ACT

A significant amount of controversy has arisen around the nature of the hearing officer for the supplemental security income program which raises issues of a basic philosophical and organizational nature concerning the appeal of SSI disability claims. It also raises issues of immediate import to the implementation of SSI since as of this date no hearing officers have been appointed and claims are beginning to reach the hearing stage.

Public Law 92–603, which established the SSI program, was approved by the President on October 30, 1972. On November 16, 1972, the Department of Health, Education, and Welfare requested that the Civil Service Commission establish registers for administrative law judges to hear SSI cases. The Department's request touched off an incredible series of developments.

The issue was quickly joined when on November 24, 1972, the Civil Service Commission's Office of Administrative Law Judges declined to establish registers or classify such positions on the grounds that the Social Security Act did not require that SSI hearings be held under the Administrative Procedure Act and therefore the Commission was powerless to act. The dispute was unresolved for the next 13 months with: (1) numerous exchanges of letters between HEW and the Commission, (2) an opinion of the Office of Legal Counsel, Department of Justice in the summer of 1973, (3) an appeal by Secretary Weinberger to the Commission citing "a crisis * * * in HEW's preparation to implement the new supplemental income program * * *" in October 1973, (4) a response from the Chairman of the Civil Service Commission in late October which in essence granted the HEW request to establish registers for administrative law judges, (5) in December 1973 a hearing before the full Commission called at the request of several "model agency" ALJ's, and (6) a reversal of the decision made in October by the Chairman. The decision of the full Commission was dispatched to HEW on the *14th of December, 1973* and essentially carries out the original letter of rejection sent to HEW by the Civil Service Commission over a year previously. The decision stated that the Commission had concluded that administrative law judges are not required to preside over SSI hearings because the program is not under the APA. Therefore, the Secretary of HEW should go ahead under his own appointing authority to appoint hearings examiners at GS–13 and an appropriate number of supervisory hearings examiners at GS–14. In answer to the Department's immediate need, the Commission stated that regulations promulgated pursuant to the Administrative Procedure Act would allow the temporary assignment (for up to 120 days) of regular administrative law judges (GS–15) to SSI cases where this was not inconsistent with their regularly assigned duties. (For a chronology of developments up to the final Commission decision see minutes of Civil Service Commission meeting in appendix A.)

The discussion in the following pages deals with the questions of whether the Administrative Procedure Act applies to SSI hearings and the immediate administrative and policy ramifications of the Civil Service Commission's decision that the APA does not apply.

LEGISLATIVE BACKGROUND

The Ways and Means Committee has consistently maintained that the APA applies to Social Security title II and title XVIII cases.

Although most of the courts which have dealt with the issue have believed that the APA does apply, the Circuit Court in the *Perales* case found otherwise. The Supreme Court, however, found it unnecessary to decide the issue. In *Perales* the claimant was asserting, and was joined in this by an amicus brief filed by the American Bar Association, that the issues before the court as to hearsay evidence and the right of cross-examination, as well as other procedures relating to administrative hearings for disability and other social security claims, were governed by the APA rather than the Social Security Act. The Administration's brief argued that the Social Security Act provisions were not inconsistent with the provisions of the APA and concluded:

> Consequently, as the American Bar Association's brief recognizes, the Secretary's exercise of his authority under the Social Security Act does not conflict with the provisions of the Administrative Procedure Act. While the court below held the Administrative Procedure Act inapplicable to the conduct of hearings under the Social Security Act on the ground that 5 U.S.C. 556(b) states that the entire administrative procedure subchapter (5 U.S.C. 551–559 "does not supersede the conduct of specified classes of proceedings, in whole or in part by or before boards or other employees specifically provided for by or designated under statute" (App. 42), there is no occasion for this Court here to consider the correctness of that broad ruling.

The Supreme Court generally adopted the Administration's argument stating:

> We need not decide whether the APA has general application to social security disability claims, for the social security administrative procedure does not vary from that prescribed by the APA.[1]

The legislative history of the law establishing the SSI program makes it clear that the committee intended that the hearings conducted under the new program are to be under the APA but that the Secretary would be given the discretionary authority to appoint examiners who could not fully meet the rather stringent requirements of adjudication or court experience for appointment as a hearing examiner (now called an Administrative Law Judge) under the APA. In the confidential print prepared by HEW and Ways and Means staff (February 8, 1971) which described proposed Administration amendments to H.R. 1 the following appears:

> Under the provisions of H.R. 1, all hearing examiners must be qualified under the standards in the Administrative Procedure Act.
>
> *Change proposed by the Department*
>
> Hearings would be conducted in accordance with procedures of the APA but examiners would not have to be appointed under the conditions set forth in the act.
>
> *Rationale*
>
> Many qualified persons experienced in State welfare determinations may not meet the specific requirements for hearing examiners under the APA standards, but will be an excellent source of examiners to hear issues arising under the Family Assistance Act.

The Committee report also reflects this view:

> Your Committee recognizes that many qualified persons who would be capable of hearing issues that arise under the program may not meet the specific requirements for appointment as hearing examiners under the Administrative Procedure Act, but might be a good source of examiners to hear issues arising under the program. Therefore under your committee's bill the Secretary would establish the requirements to be used in selecting examiners. Although the examiners would not be selected under the conditions set forth in the Administrative Act, full hearings would otherwise be conducted in accordance with the requirements of such Act which include, for example, the right to submit evidence, to cross examine witnesses, to be heard by an impartial examiner and to a decision based on the hearing record.[2]

It is important to keep in mind that the main focus of the Committee on Ways and Means when this action was being considered was on the proposed family assistance plan, which would have required an administrative appeals mechanism of far greater magnitude than the adult assistance program. Parallel language applicable to the adult assistance program was contained in H.R. 1 and the accompanying Committee report.

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[1] See app. B for materials relative to the applicability of the APA to Social Security appeals: briefs submitted by Administrative Law Section, American Bar Association and Justice Department together with pertinent part of decision from Supreme Court decision in *Richardson* v. *Perales* (1971) 402 U.S. 387.

[2] H. Rept. No. 92–231.

The SSI provision (sec. 1631(c)) requires the Secretary to provide reasonable notice and opportunity for a hearing to any individual who is dissatisfied with the determination made on his claim for benefits. The final determination of the Secretary (after a hearing) is subject to judicial review as provided for old age, survivor's, and disability insurance claims in section 205(g) of the Social Security Act, except that under the SSI program "the determination of the Secretary after such hearing as to any fact shall be final and conclusive and not subject to review by the court." Section 1631(d)(2), the crucial provision, provides:

> To the extent the Secretary finds it will promote the achievement of the objectives of this title, qualified persons may be appointed to serve as hearing examiners [now titled administrative law judges] in hearings under subsection (c) without meeting the specific standards prescribed for hearing examiners by or under subchapter II of chapter 5 of title 5, United States Code.

Title XVI establishing SSI as finally enacted was a redesignation of title XX of the House-passed version of H.R. 1. The provisions applicable to the SSI program were identical in both the House and Senate versions. The Senate Report, however, did not contain the Ways and Means language previously cited. Evidence of the congressional intent as to the applicability of the APA to SSI hearings is found in the comment of Chairman Mills when he specifically stated on the Floor:

> The hearings to which the bill refers would be subject to the Administrative Procedure Act and all the safeguards for a fair and equitable hearing in the act would apply to the hearing.[3]

Mr. Carey immediately thereafter declared:

> The gentlemen pointed out that the Administrative Procedure Act does cover the review of benefits under this bill. It has been erroneously contended it did not.

Mr. Martin, the committee's chief counsel, summed up the legislative history on this question in a letter dated January 24, 1973, to Mr. Dale Cook, Director, Bureau of Hearings and Appeals, wherein he states that this section deals exclusively with the authority of the Secretary to appoint hearing examiners and that this provision in no way vitiates the explicit language of the committee report that all hearings are to be conducted in accordance with the APA. Mr. Martin further stated that the official legislative record on H.R. 1 reflects that no member of the committee expressed any contrary view.

The Civil Service Commission bases its final decision on this matter primarily on the opinion of its General Counsel, Anthony B. Mondello, bolstered to some degree by a memorandum of the Office of Legal Counsel, Department of Justice.[4] The crux of Mondello's argument is that if Congress merely had wanted to waive the standards for appointment of ALJ's under the APA the statute should have specifically referred to the section in Title V which governs such appointments, namely section 3105, (this section which outlines the specific qualifications for ALJ's was codified outside the other operative sections of the APA which are contained in "subchapter II of chapter 5 of Title 5, United States Code".) Granted that perhaps it would have been better drafted by a reference to section 3105, the intent of the provision seems to be quite clear from the legislative history. Mr. Mondello, however, dismisses these considerations rather summarily by stating:

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[3] 117 Congressional Record at 5658.

[4] At the time, Robert G. Dixon (who is quoted elsewhere in this report) was serving as Assistant Attorney General, Office of Legal Counsel. Mr. Dixon seems to favor the Civil Service Commission interpretation but indicates that the safest "legal" course of action is to follow the course recommended by HEW—e.g., a hearing process containing all the APA safeguards and conducted by an APA administrative law judge. This, in his view, was the only sure guarantee against subsequent judicial action voiding thousands of hearings if APA requirements for both hearings and those presiding at the hearings are not followed.

> There is some further reference to the applicability of the APA in the House floor debates, * * * but one must be wary of basing Congressional intent on the statement of individual members of only one of the two houses of the legislature, particularly where even the more broadly based Committee reports are ambiguous on the same issue.

Problems Facing Bureau of Hearings and Appeals

As stated previously, the Bureau of Hearings and Appeals has not appointed any hearings examiners and some nondisability SSI cases have already come up for hearing. (Initially it was estimated that there would be 82,600 SSI hearings requests in fiscal 197 but this obviously did not materialize.) Moreover, a deluge of Black Lung cases—35,000 pending and several hundred new cases a week—are descending on BHA and cannot be handled by the limited number of temporary Black Lung ALJ's. Thus, BHA has required its regular Title II and Title XVIII ALJ's to come to the Black Lung States to hear and decide 40 cases each (16,000 in all), to help meet this workload. Needless to say, their regular caseload has suffered and their ability to be the back-up for SSI hearings will be greatly impaired. Approximately 12,000 Black Lung cases have been decided as of mid-June.

There are also some very practical problems involving employee morale in creating SSI examiners one or two grades lower than regular Social Security ALJ's. In large part both groups will be adjudicating cases of equal difficulty but with distinctly unequal status. Moreover, from the claimant's viewpoint a Title II disability applicant gets a "judge" while an SSI applicant gets only a lower grade "examiner". There are already some indications of disenchantment by the regular ALJ's who have already had to go into Black Lung to help out the temporary (GS–14) Black Lung examiners [5] and now will be asked to adjudicate SSI cases which have been deemed by the Civil Service Commission Office of Amdinistrative Law Judges as a procedures of lesser importance than those under Title II. There is really no explanation by the Civil Service as to why the SSI adjudications are of lesser importance apart from the point that they normally involve smaller benefits and are "nonadversary" procedures. The Commission also pointed out that the standard of court review is different in that SSI findings of facts are supposed to be binding on the Courts, but this would seem to argue for greater importance of the findings of the fact in SSI cases and enhance this determination.

The Civil Service Commission (more particularly its Office of Administrative Law Judges) seems to have been convinced by the argumentation of those Administrative Law Judges from "old line" agencies who appeared before the en banc meeting of the Commission in December stating that it is a mistake to have ALJ's preside over Social Security Title II cases and to have them for SSI would further compound the "classification error." (See minutes of Commission session in appendix A.) These ALJ's put great weight on the proposition that Social Security claims do not involve adversary proceedings. It should be noted however, than when Covington and Burling examined the appeals system and stated that the APA did not require Bureau Representatives at the hearing and recommended against such a development toward an adversary proceeding it stated that: "it is only fair to add that in evaluating the relative status of Social Security Hearing Examiners as compared with Hearing Examiners serving elsewhere in Government, recognition should be given to the fact that the absence of Bureau counsel materially increases their responsibility as well as their work" (Horsky report, p. 335).

Clarifying Amendment

To carry out the original intention of the Committee, certain language of a technical and conforming nature could be adopted to meet the mechanistic interpretation of the Civil Service Commission and, to a lesser degree, the Justice Department. Such language was proposed by the Administration in its recommendations to the Senate for additional technical and conforming amendments to H.R. 3153, but the Senate did not adopt it. The proposed amendment is shown in the following Ramseyer format with the new language italicized and the language to be struck bracketed:

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[5] Black Lung administrative law judges can only handle Black Lung cases. Their temporary appointments would have expired at the end of this calendar year but the Supplemental Appropriations Act extends them through calendar year 1975.

> Section 1631(d) (1) The provision of section 207 and subsections (a), (d), (e), and (f) of section 205 shall apply with respect to this part of the same extent as they apply in the case of title II.
>
> (2) To the extent the Secretary finds it will promote the achievement of the objectives of this title, qualified persons may be appointed to *conduct* [serve as hearing examiners in] hearings under subsection (c) without meeting the *requirements* [specific standards prescribed] for hearing examiners *appointed under section 3105* [by or under subchapter II of chapter 5] of title 5, United States Code.

Further amendment of section 1631(d) perhaps is desirable to counter the argument that the APA does not apply to SSI. The General Counsel of the Civil Service Commission argues that Title XVI provides only for "reasonable notice and opportunity for a hearing" but there is no explicit requirement that the determination be made "on the record" as required by section 554(a) of the APA. The HEW General Counsel argues that the cross reference in section 1631(d)(1) to 205(g) meets the "on the record" requirement because, on judicial review, "the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based." However, there seems to be no good reason for not including the language which appears in Title II (sec. 205(b)) which is not cross referenced in section 1631(d)(1). Section 205(b) states after the "reasonable opportunity for hearing" phrasing that if a hearing is held the Secretary shall "on the basis of the evidence adduced at the hearing, affirm, modify, or reverse his finding of fact and such decision." Inclusion of this 205(b) language would appear to strengthen the argument that the determination is "on the record."

The omission of the reference in section 1631(d)(1) to section 205(b) may also raise a question under *Richardson* v. *Perales* (1971) 402 U.S. 410 as to whether SSI medical reports can be introduced in evidence because of their hearsay nature. Section 205(b) states in the final sentence that "evidence may be received at any hearing before the Secretary even though inadmissible under rules of evidence applicable to court procedure." It is true that section 205(a), which is cross referenced, does give the Secretary authority to adopt "reasonable and proper rules and regulations to regulate and provide for the nature and extent of proofs and evidence" but a court might conceivably find the specific lack of reference to the provision in 205(b) indicates an intent to have the formal rules of evidence apply.

APPENDIX A

Minutes of Civil Service Commission Meeting

Meeting of December 3, 1973, before the Civil Service Commissioners to review hearing officer staffing for HEW's Supplemental Security Income Program

BACKGROUND

Title III of Public Law 92-603, the Social Security Amendments of 1972, transfers to the Federal Government (HEW) from the States the responsibility for providing financial aid to the aged, the blind, and the disabled.

For those claimants who disagree with a determination as to coverage or the amount of benefits, the law affords a hearing. The requirement for a hearing is found in Section 1631(v) of Title XVI of the Social Security Act, as amended.

Section 1631(d)(2) provides:

> To the extent the Secretary (of HEW) finds it will promote the achievement of the objectives of this title, qualified persons may be appointed to serve as hearing examiners in hearings under subsection (c) without meeting the specific standards prescribed for hearing examiners by or under subchapter II of chapter 5 of title 5, United States Code.

The above reference to "subchapter II of chapter 5" is to the codified portion of the Administrative Procedure Act under which Administrative Law Judges (formerly known as hearing examiners) conduct hearings and other proceedings.

Prior to final enactment of PL 92-603, both the Commission and HEW recognized that the language of the bill (H.R. 1) did not clearly define what type of SSI hearings would be afforded nor what type of hearing officer would preside. Their efforts at clarification, however, failed and H.R. 1 became law on October 30, 1972.

On November 16, 1972, HEW requested the Commission to establish registers of qualified Administrative Law Judges to serve as SSI hearing officers. The Commission's office of Administrative Law Judges, by letter of November 24, 1972, declined to establish such registers or to classify such positions on the grounds that the Social Security Act, as amended, did not *require* that SSI hearings be held under the Administrative Procedure Act and therefore the Commission, by its own regulations, could not supply Administrative Law Judge registers in the absence of a statutory requirement.

In March 1973, the Director of SSA's Bureau of Hearings and Appeals, with a supporting legal opinion from HEW's Assistant General Counsel, again asked the Commission to classify the SSI Hearing Officers as APA ALJs. The Commission's Office of Administrative Law Judges again declined.

On April 9, 1973, HEW's General Counsel Hastings wrote to CSC's General Counsel Mondello asking for assistance in resolving questions concerning the type of hearings to be afforded in the SSI program and the type of hearing officer to preside. Mr. Hastings stated that in his opinion the Administrative Procedure Act did apply and that Administrative Law Judges should preside at the SSI hearings.

On May 9, 1973, Mr. Mondello responded, in part, "After carefully considering the arguments which have been presented with regard to this question it is my opinion that section 3105 Administrative Law Judges are not required to preside over these hearings. Rather, it is the power of the Secretary of HEW to appoint individuals to fill these positions as he would other positions at HEW. As a result, I do not feel that the Civil Service Commission should provide section 3105 ALJs to conduct these hearings. While I reach a conclusion different from yours in this matter, I recognize the weight of the arguments you have presented in favor of APA application. Therefore, I would gladly join with you in pressing for an opinion of the Attorney General to resolve this basic conflict, particularly since the consequences of proceeding incorrectly, i.e., upset in the courts, is a matter in which the Department of Justice will bear litigation responsibility. For purposes of determining the applicability of the APA the language Congress has given us in title XVI is terribly ambiguous. On the face of the statute alone I could not conclude that Congress intended the APA to apply. I would, in fact, reach the opposite result. . . ."

In June 1973 HEW's General Counsel sought the views of the Attorney General, Office of Legal Counsel.

On July 10, 1973, CSC's General Counsel wrote a letter to the Department of Justice which, among other matters, solicited the Department's views on hearings under the SSI program.

On August 13, 1973, pending a response from the Department of Justice and in keeping with plans for a standby hearing examiner recruiting program on their own, HEW requested the Commission to approve the classification of the new positions at GS–13 and GS–14 in the regular attorney series. The Commission's Bureau of Personnel Management Evaluation advised that the highest supportable grade for the positions in the GS–905 attorney series was GS–13.

HEW was displeased with the GS–13 grade determination, as well as with the Commission's posture with regard to the nonapplicability of APA to SSI hearings, and so the two agencies jointly proceeded to elicit an opinion from the Attorney General.

On October 5, 1973, Assistant Attorney General Dixon responded by cover letter with a 38-page attachment. In his covering letter, Mr. Dixon said, in part, "Our memorandum points in the direction of going forward with HEW-appointed, non-APA, hearing examiners. The fundamental question is the degree of risk of court reversal, and of subsequent re-hearing of denied claims . . . ."

Mr. Dixon's memorandum explored "a possible middle ground." The middle ground, as he saw it, would have HEW decide administratively to apply APA to SSI hearings with the exception that the hearing officer would not be an APA administrative law judge. He said, "If the hearing examiners so appointed were carefully separated from the control of agency personnel who have investigative or prosecutorial duties, neither due process (as expressed in *Goldberg* v. *Kelly*) nor the spirit of APA (which requires an impartial hearing officer) would be violated. This interpretation would also avoid diluting the prestige of the present administrative law judge cadre which is composed primarily of GS–15's and 16's, by keeping the new GS–13 hearing examiners within the confines of HEW . . . ." Mr. Dixon continued by pointing out that "if a decision is made to appoint non-APA hearing examiners, subject to the control of HEW, and that decision proves wrong, there may be thousands of denials requiring rehearing."

It can be fairly stated that the Dixon memorandum argued both sides of the question—APA vs. non-APA—and concluded with a statement of need for a national study commission and further legislation to clear up many of the gray areas in Federal adjudicatory processes.

By letter of October 12, 1973, HEW Secretary Weinberger appealed to Chairman Hampton for resolution of what he termed "a crisis . . . . in HEW's preparations to implement the new Supplemental Security Income program . . . . "

Specifically, the Secretary urgently requested that the Commission:

1. classify the SSI hearing officer positions in the GS–935 Administrative Law Judge series.
2. establish positions for these officers at both the GS–13 and GS–14 levels, and
3. establish registers and follow full APA procedures with respect to the selection and control of these hearing officers.

On October 23, 1973, the Commission's Deputy Executive Director convened a meeting of HEW and CSC representatives in an effort to resolve the impasse by proposing and considering the development of a new series to be used as a basis for a competitive examination to be conducted by the Commission, thus resulting in competitive appointments (which would not be possible under the Attorney series) as much like Administrative Law Judge appointments as feasible. After discussion and consideration, the proposal was rejected by the HEW representatives.

On October 30, 1973, upon the recommendation of the Commission's Deputy Executive Director, Chairman Hampton signed and dispatched a letter to HEW Secretary Weinberger, in which he said in conclusion: "In summary, the Commission is willing to establish the SSI positions in the GS–935 series (Administrative Law Judges), to consider any further information the Department has relative to the grade level of the subject positions, and to initiate a recruitment program in line with the standards now followed in the Administrative Law Judge program."

On November 12, 1973, Arthur A. Gladstone, an Administrative Law Judge at the Federal Communications Commission and Chairman of the Conference of Administrative Law Judges, wrote to the Commissioner denouncing the decision to place SSI hearing officers in the Administrative Law Judge series, claiming that to do so is inimical to the purpose and intent of the Administrative Procedure Act, and requesting that this matter be reviewed by the Commissioner *en banc*.

On November 16, 1973, a similar letter was received from John M. Dyer, an Administrative Law Judge at NLRB and President of the Federal Administrative Judges Conference. He stated his position that establishment of the positions in the GS–935 series contravenes section 3105, title 5, U.S. Code and Section 930.202(c) of the Code of Federal Regulations. He, too, requested that this matter be reviewed by the full Commission.

On November 16, 1973, Stanley N. Ohlbaum, an Administrative Law Judge at NLRB and Chairman of the Committee on Administrative Law Judges of the Federal Bar Association, wrote the Commissioners for a suspension of the decision of October 30, 1973, a reconsideration by the full Commission, and an opportunity for all interested parties to be heard.

The above three requests were honored and arrangements were made for a meeting to be held before the Commission *en banc* on December 3, 1973.

THE MEETING

The meeting got underway at 9:10 a.m. with Chairman Hampton presiding, assisted by Vice Chairman Spain and Commissioner Andolsek.

Also present were the following Commission officials: Executive Director Rosen; Deputy Executive Director Dunton; General Counsel Mondello; Mr. Dullea, Director of the Office of Administrative Law Judges; Mr. Kistler, Deputy Director of the Bureau of Policies and Standards; and other support personnel.

HEW officials and support personnel present were: SSA Deputy Commissioner Arthur Hess; H. Dale Cook, Director, SSA's Bureau of Hearings and Appeals; Sumner G. Whittier, Director, SSA's Aged, Blind and Disabled Office of Planning Assistance; HEW Assistant General Counsel Manuel Hiller; Mr. William M. Russell, Deputy Assistant Secretary for Personnel and Training; Messrs. Gonya, Brown, Matthews, Naquin, Acquisto; Mr. Carlile Bolton-Smith, Chairman, Committee on HEW, Administrative Law Section, American Bar Association; and HEW Administrative Law Judges Mason, Boroweic, Fier, and Hartkey.

Judges Gladstone, Dyer, and Ohlbaum (who requested the en banc review) were also present.

Chairman Hampton made an opening statement which can be summarized as follows: It appears that we all agree that the Social Security Act, as amended, does not require SSI claimant hearings to be held under the Administrative Procedure Act nor to be presided over by Administrative Law Judges. It appears also that we agree that the controlling statute, as amended, is ambiguous in its construction with regard to what kind of hearing and what kind of presiding officer.

The question then becomes: (1) what did Congress intend? (2) in the absence of a clear Congressional intent, what then becomes legally necessary through other statutes, court decisions, etc., in terms of structure, procedure, and presiding hearing examiner to conduct SSI hearings? and (3) what is administratively desirable in order to afford due process to claimants—due process that will withstand judicial scrutiny—and in order to enable HEW to carry out in an expeditious and orderly fashion a new public program established by the Congress and reflecting the will of the people?

He then invited HEW officials to review the establishment of the SSI program, and to offer any and all information in support of their position.

SSA Deputy Commissioner Hess was the main spokesman for HEW. He agreed that the law is ambivalent and that the manner of handling SSI claimant hearings is "profoundly a matter of policy." He urged the full Commission to adhere to the earlier agreement to go the APA route with ALJs presiding. To do otherwise, he said, would be to deny essential rights to claimants.

Commissioner Hess reviewed the handling of claims within the Social Security Administration. SSA now has 450 ALJ's who are under APA, and the appeals process is thoroughly decentralized for "customer convenience." The regular case load is around 75,000 cases a year with a 4-5 months backlog pending plus an additional 20,000 black lung cases pending. He said that HEW expects about 60-80,000 cases the first year under SSI, and that the new SSI program, too, will be thoroughly decentralized so that the claimant can come face-to-face with the decision-maker with or without his attorney. If the claimant is not satisfied with the original decision, he can ask for a review. If he is still not satisfied, he can ask for a hearing before an Administrative Law Judge (or whatever presiding officer is decided).

Commissioner Hess urged that full APA procedures be applied under SSI as under SSA—that the Department and the Commission should not create artificial distinctions between types of due process accorded climaints under the two programs. Sometimes a claimant will have a claim filed under both programs and separate adjudicatory processes would be administratively unsound and confusing to the claimant. Also, HEW wants SSI under APA in order to assign the entire corps of ALJ's freely wherever the workload peaks. If a separate system is installed under SSI, then the SSA ALJ's may not be interchangeable with the SSI hearing officers—and vice versa.

He said he felt Congressional intent was best expressed by House Ways and Means Chairman Wilbur Mills, whose committee handled H.R. 1 in the House, and who said on the House floor that "all of the safeguards for a fair and equitable hearing in the APA would apply to these hearings." He said he was aware that Assistant Attorney General Dixon "came out differently" in his assessment of Mr. Mills' statement.

In summary, he urged the Commissioners to endorse HEW's determination to accord a lowly private citizen—a welfare recipient—the same rights as the Government accords a powerful corporation in contested matters: namely, the right to appear before an Administrative Law Judge under the full rights and protection of the Administrative Procedure Act.

He repeated that the Government should do so as a "matter of policy." To do otherwise might result in judicial overthrow which would necessitate rehearing of thousands—or even hundreds of thousands—of claims—an event which would certainly be disastrous.

Upon the conclusion of Commissioner Hess' presentation, Chairman Hampton asked for questions of a clarifying nature. Commissioner Andolsek brought up the matter of the "middle ground" suggested earlier by Commission staff. Commissioner Hess said he knew nothing about it, but after discussion among his staff while seated at the meeting table, he then stated he agreed it should have been rejected by HEW. He then repeated his earlier points on paralleling SSI procedures with SSA to promote due process, efficiency, interchange of ALJ's, and public understanding.

Chairman Hampton invited Judge Gladstone to "lead off" in presenting viewpoints opposing the HEW position.

Judge Gladstone said he did not represent the official views of the Conference of Administrative Law Judges [they had not met on the matter] but that he did represent the views of the executive committee.

The question, he said, must be reviewed—not as a matter of policy—but as a matter of law. SSI is not under APA by law, he stressed. He questioned whether CSC has legal authority to bring the SSI program under APA when the Congress itself explicitly failed to do so.

He said he endorsed the "middle ground" as suggested earlier.

Chairman Hampton then invited Judge Dyer to comment.

Judge Dyer said that he was representing the official views of the Federal Administrative Law Judges Conference which had met and taken a position.

He said the Conference opposed going APA and ALJ administratively in the SSI program; rather, the Conference's position is what does the law require? Nothing more.

He cited Assistant Attorney General Dixon's memorandum which states clearly that ALJs are not required in the SSI program. He reiterated: this is not a matter of policy—rather, it is a matter of law. And the Conference supports the law.

Chairman Hampton then invited Judge Ohlbaum to comment.

Judge Ohlbaum said that he did not represent the Federal Bar Association but that he was authorized to present the official views of the ALJ Committee of the Federal Bar Association.

He said the Federal Government has two kinds of ALJs: those in the "model agencies" such as NLRB, FCC, FTC, etc., who are full APA instruments in that under APA they make decisions awarding large sums of money, radio and TM licenses, rights-of-way, etc. Then, he said, there is the "other kind"—namely the ALJs under the SSA program whose cases are vastly different from those handled in the model agencies. He said the SSA ALJs review files and rule on the record unless the claimant submits a request for a hearing. A key distinction, he said, is that under SSA, the Government is never represented. He said it was a mistake long ago when the decision was made that hearings would be presided over by ALJs and that SSI ALJ authorization would further compound the "classification error."

He cited former Secretary of HEW Cohen's testimony against using APA for the SSA program in which he said that such a route would force claimants to hire lawyers and would pit Government against the citizen, would be inefficient, and "drawn out."

Judge Ohlbaum urged that ALJs not be authorized for the SSI program.

Chairman Hampton then opened the meeting for general comment.

Judge Boroweic, an Administrative Law Judge of HEW, argued in favor of his agency's position. He said that the use of ALJs in the SSA program was not a mistake and that proof exists in the fact that some 2,000 SSA cases go to court every year and there are *very few* reversals of the ALJs position.

Mr. Cook, Director of SSA's Bureau of Hearings and Appeals, then took issue with the Commission for its classification of the proposed positions at GS–13 and its denial of GS–14. He said he could not imagine a successful recruiting campaign for GS–13's when they would have to be told it was a "dead-end" job with no growing room. He also defended the use of ALJs in the SSA program and said it would be unthinkable to use "something less than this" in the SSI program.

Following a round-robin of scattered comments on both sides of the question, Chairman Hampton then asked if both sides felt they had been adequately heard—if they would like to present anything additional.

There was general agreement that "both sides" might well use an opportunity to "go back and rethink" and to present additional information for consideration by the Commissioners.

Chairman Hampton suggested a 2-day deadline with which both sides agreed. The Chairman thanked the participants for coming and assured them the full Commission would decide the matter expeditiously—but not until the 2-day deadline had expired. He said he knew the SSI program had to be kept moving but that he was distressed the matter had not reached the Commissioners until *a full year* after the law was enacted. He assured the group that further unconscionable delay would not be caused by the Commissioners.

With no one wishing to make further comment, Chairman Hampton adjourned the meeting at 11:45 a.m.

JAMES C. SPRY,
Executive Assistant to the Commissioners.

APPENDIX B

Briefs and Excerpt from Supreme Court Opinion in *Richardson* v. *Perales*

American Bar Association Brief

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1970

No. 108

ELLIOT L. RICHARDSON, SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
PETITIONER

v.

PEDRO PERALES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

This appeal arises from the claim of a private individual for social security benefits based upon disability.

The American Bar Association became interested only when the court of appeals stated in its opinion issued on May 1, 1969 that the Administrative Procedure Act did not apply to cross-examination in disability hearings before hearing examiners appointed under Section 11 of the Administrative Procedure Act and employed by the Social Security Administration of the Department of Health, Education, and Welfare (App. 42)

The Association supported enactment of the Administrative Procedure Act. Through its Administrative Law Section it has sought to preserve the improvements in the Federal administrative process achieved by that statute. With the approval of the Association's Board of Governors, a brief amicus curiae was filed with the court of appeals, when the Secretary sought rehearing, in an effort to persuade that court to amend its statement regarding the applicability of the Administrative Procedure Act. The court of appeals declined to to amend its opinion in this regard.

After the Secretary filed his brief in this court, authorization was sought and obtained on August 7, 1970 from the Association's Board of Governors to file the attached Brief Amicus Curiae with this Court in opposition to the Secretary effort to persuade this Court that the Administrative Procedure Act does not apply to hearings under the Social Security Act. In view of the time exigencies, no attempt has been made to obtain the assent of the parties to the filing of this motion and the accompanying Brief Amicus Curiae.

WHEREFORE, the American Bar Association respectfully requests permission to file with the court, for its consideration, the attached Brief Amicus Curiae.

Respectfully submitted.

AMERICAN BAR ASSOCIATION,
By FRANKLIN M. SCHULTZ,
Chairman, Administrative Law Section.
JOHN T. MILLER, JR.,
Its Attorneys.

AUGUST 1970.

BRIEF AMICUS CURIAE OF THE AMERICAN BAR ASSOCIATION

PRELIMINARY STATEMENT

This appeal arises from a claim for social security benefits under the disability provisions of the Social Security Act, 42 U.S.C.A. Sections 416(i)(1) and 423. The claimant was denied relief after a hearing held on a record before a hearing examiner appointed under the Administrative Procedure Act (APA). The issue on appeal involves the weight to be given medical reports of physicians who examined the claimant but who were not present at the hearing in which their reports were admitted into evidence.

In affirming a district court decision requiring a new administrative hearing, the court of appeals stated in its original opinion that "the Administrative Procedure Act does not control the method of conducting hearings under the Social Security Act, if in conflict therewith, and the right of cross-examination provided for in the former will not prevail over the procedures established by the Secretary under the latter statute." (App. 42) When rehearing was sought by the Secretary, the American Bar Association filed an amicus brief arguing that the issues before the court could and should be determined under the Administrative Procedure Act. The court of appeals declined to modify its opinion in this regard. (App. 54)

In the brief for petitioner filed in this Court, the Secretary has avoided any reference to the Administrative Procedure Act. The Social Security Act is considered a sufficient source of the Secretary's regulation of the administrative procedures in social security cases. Although the statutory provisions of the Social Security Act relied upon by the Secretary were enacted prior to the time the APA became law, the Secretary asserts that the "only basis on which these statutory provisions could be attacked would be that they operate, in some way, to deny 'due process of law,' contrary to the Fifth Amendment." (Pet. Br. 16)

The American Bar Association takes no position on the merit of respondent's claim, nor does it take issue with the decision of the court of appeals insofar as it affirms the district court. What is of concern to the Association is the complete denial of access to the rights assured by the APA implicit in the argument asserted by the Secretary in this Court.

We respectfully submit that this case can and should be decided under the APA, a statute that permits the introduction of hearsay evidence in appropriate cases through procedures which can be harmonized with the right of cross-examination.

I.

THE ADMINISTRATIVE PROCEDURE ACT APPLIES TO HEARINGS ON DISABILITY CLAIMS

The Administrative Procedure Act applies in "every case of adjudication required by statute to be determined in the record after opportunity for an agency hearing". (5 U.S.C.A. § 554(a)) Hearings on disability claims do not come under any of the six exceptions to this statutory requirement.

The Social Security Act provides an opportunity for hearing. Disability claimants dissatisfied with initial action on their claims by the Secretary are entitled by statute "to a hearing thereon by the Secretary to the same extent as is provided in section 405(b)" of Title 42. (42 U.S.C.A. § 421(d)). Section 405(b) provides that the Secretary, upon request, shall give a dissatisfied claimant

> "reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of the evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision."
>
> In *Wong Yang Sung* v. *McGrath*, 339 U.S. 33, 50 (1950), this Court said: "We think that the limitation to hearings 'required by statute' in § 5[5 U.S.C.A. § 554(a)] of the Administrative Procedure Act exempts from that section's application only those hearings which administrative agencies may hold by regulation, rule, custom, or special dispensation; not those held by compulsion."

The determination of a disability claim, after hearing, is an adjudication within the meaning of the APA, inasmuch as it is an "agency process for the formulation of an order" (5 U.S.C.A. § 551(7)), an order reviewable by the courts under the APA. See *Cappadora* v. *Celebrezze*, 356 F. 2d 1, 5 (2d Cir. 1966).

The adjudication in a disability case is determined on the record. The Secretary's action must be based on evidence under section 405(b). Under section 405(g), relating to court review, the Secretary is required to file with the court "a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based." (42 U.S.C.A. § 405(g))

The provisions of sections 405(a) and (b) of the Social Security Act, upon which the Secretary relies as a source of his power to regulate these administrative proceedings, were enacted into law as part of the Social Security Act Amendments of 1939. (See 53 Stat. 1368–1369) These provisions and the administrative procedures which had been adopted pursuant thereto by what was then called the Social Security Board,[1] were considered by the Attorney General's Committee on Administrative Procedure in recommending legislation to Congress in 1941.[2] After a study of the Board's procedures, the Committee's Staff had advised the Committee:

> "* * * Under the 1939 amendments to the act, effective January 1, 1940, the grant of a hearing is no longer optional with the Board; the Board is now required, upon request, to give opportunity for a hearing to any person whose application for benefits has been disallowed. * * *
>
> Even though no hearings have yet been held, it is nevertheless possible to study this aspect of the Board's work in anticipatory detail, because the Board has approved very elaborate plans and has formulated regulations to govern the formal hearing and review process. * * *"[3]

When making specific recommendations as to how the administrative process might be improved upon by appropriate legislation, the Attorney General's Committee assessed its recommendations in the light of the responsibilities and practices of existing federal agencies. Speaking of the Social Security Board, the Committee remarked that the "recommendations in Chapter IV relating to hearing commissioners are applicable to and largely declaratory of the existing hearing proceedings before referees [of the Board]."[4]

Congress relied upon the studies of the Attorney General's Committee in drafting the legislation which in 1946 became the APA. This is plain from the Reports of the Congressional Committees and the legislative debates.

> "In the framing of the bill herewith reported, (S. 7), your committee has had the benefit of the factual studies and analyses prepared by the Attorney General's Committee."[5]

In the course of debates in the United States Senate on S. 7, Senator McCarran, Chairman of the Senate Judiciary Committee and sponsor of the bill observed:

> "I would say that the bill takes into consideration those studies [of the Attorney General's Committee] and is guided by them."[6]

We submit that a careful reading will show that there is no actual conflict between the provisions of 42 U.S.C.A. §§ 405(a) and (b) enacted in 1939, on the one hand, and the relevant provisions of the APA enacted in 1946[7] on the other. But if there were any conflict, rules of statutory construction would require that the earlier statute give way to the later. *Gibson* v. *United States*, 194 U.S. 182, 192 (1904).

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[1] Under the 1946 Reorg. Plan No. 2, and Act of August 28, 1950, the functions of the Social Security Board were transferred to the Federal Security Administrator. (See U.S. Code Cong. Service 1946, 1667, 1669; 64 Stat. 477, 559) The functions of the Administrator were transferred to the Secretary of the Department of Health, Education and Welfare by 1953 Reorg. Plan No. 1. (67 Stat. 631, 632)

[2] Final Report of the Attorney General's Committee on Administrative Procedure, S. Doc. 8, 77th Cong., 1st Sess. (1941).

[3] Administrative Procedure in Government Agencies, Social Security Board, S. Doc. No. 10, part 3, 77th Cong., 1st Sess., 14 (1941). Professor Walter Gellhorn was director of the Staff.

[4] Final Report of the Attorney General's Committee on Administrative Procedure 157.

[5] Administrative Procedure Act, Report of the Committee on the Judiciary, United States Senate, on S. 7, a bill to improve the administration of justice by prescribing fair administrative procedure, S. Rep. No. 752, 79th Cong., 1st Sess., 4 (1945).

[6] 92 Cong. Rec. 2155, March 12, 1946.

[7] 60 Stat. 237.

The remedial nature of the APA gives further warrant to our claim that it must be given preference. It "would be a disservice to our form of government and to the administrative process itself if the courts should fail, so far as the terms of the Act warrant, to give effect to its remedial purposes where the evils it was aimed at appear." *Wong Yang Sung* v. *McGrath*, 339 U.S. at 41. If the Secretary's regulations are contrary to the plain provisions of the APA, the regulations must give way. See *Miller* v. *United States*, 294 U.S. 435, 440 (1935).

II.

CONGRESS INTENDED BY ENACTMENT OF THE APA TO PERMIT CONSIDERATION OF HEARSAY EVIDENCE WHILE PRESERVING THE RIGHT OF CROSS EXAMINATION

As previously indicated, the American Bar Association takes no position on the merits of the claim of Mr. Perales. But we think it might be helpful to the Court, in its consideration of the issues herein within the context of the Administrative Procedure Act, to consider the following notes from that statute's legislative history.

Where administrative adjudication comes within the purview of section 5 of the APA, 5 U.S.C.A. § 554, and the controversy cannot be determined by consent, the Act provides that the agency must give all interested parties opportunity for "hearing and decision on notice and in accordance with" sections 7 and 8 of the APA (now 5 U.S.C.A. § § 556 and 557). Subsection 7(d) of the APA provides in relevant part:

> "* * * Any oral or documentary evidence may be received, but the agency as a matter of policy shall provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence. * * * A party is entitled * * * to conduct such crossexamination as may be required for a full and true disclosure of the facts. * * *" (5 U.S.C.A. § 556(d)).

A. Congress Intended That Hearsay Evidence May Be Admitted Into Evidence

The Senate Judiciary Committee, reporting on S. 7 which became the APA, asserted:

> "* * * Thus while the exclusionary 'rules of evidence' do not apply except as the agency may as a matter of good practice simplify the hearing and record by excluding obviously improper or unnecessary evidence, the standards and principles of probity and reliability of evidence must be the same as those prevailing in courts of law or equity in nonadministrative cases. There are no real rules of probity and reliability even in courts of law, but there are certain standards and principles—usually applied tacitly and resting mainly upon common sense—which people engaged in the conduct of responsible affairs instinctively understand and act upon. They may vary with the circumstances and kind of case, but they exist and must be rationally applied. These principles, under this subsection, are to govern in administrative proceedings." [8]

During the Senate debates on S. 7, Senator McCarran discussed the admissibility of evidence under the proposed statute in these terms:

> "* * * So we said to [the agencies], 'You may go outside and get what would be secondary evidence, or hearsay; you may perhaps even go into the realm of conjecture; but when you write your decision it must be based upon probative evidence and nothing else. If in the formation of your decision you consider other than probative evidence, your decision will be subject to being set aside by a court of review.'

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[8] S. Rep. No. 752, *supra*, 22 (1945). Similar language may be found in the Report of the House Committee on the Judiciary on S. 7. See H. Rep. No. 1980, 79th Cong., 2d Sess., 36 (1946). See also Davis, *Administrative Law Treatise* § 14.05 (1958).

> "In other words, we did not wish to destroy the administrative agencies or prescribe the methods under which they have been operating. * * * I doubt very much if any hearing is ever conducted in which, to some extent, hearsay is not admitted. But we believed, and we now believe, that reasonable men can sift the grain from the chaff. Then we laid down the rule that the administrative agencies must not make a finding which impinges upon an individual unless there is behind such finding probative evidence to sustain it. That is what we have worked out in this bill. * * *"[9]

B. The Right of Cross-Examination Is Protected by the APA

Turning now to the right of cross-examination guaranteed by subsection 7(d) of the APA, 5 U.S.C.A. § 556(d), The Senate Judiciary Committee asserted:

> "The right of cross-examination extends, in a proper case, to written evidence submitted pursuant to the last sentence of the subsection as well as to cases in which oral or documentary evidence is received in open hearing. * * * To the extent that cross-examination is necessary to bring out the truth, the party should have it. * * *"[10]

The House Judiciary Committee expressed similar views:

> "The provision on its face does not confer a right of so-called 'unlimited' cross-examination. Presiding officers will have to make the necessary initial determination whether the cross-examination is pressed to unreasonable lengths by a party or whether it is required for the 'full and true disclosure of the facts' stated in the provision. Nor is it the intention to eliminate the authority of agencies to confer sound discretion upon presiding officers in the matter of its extent. The test is—as the section states—whether it is required 'for a full and true disclosure of the facts.' * * * The right of cross-examination extends, in a proper case, to written evidence submitted pursuant to the last sentence of the section as well as to cases in which oral or documentary evidence is received in open hearing. * * * To the extent that cross-examination is necessary to bring out the truth, the party must have it. * * *"[11]

CONCLUSION

The Administrative Procedure Act applies to social security cases. It permits consideration of hearsay evidence while preserving the right of cross-examination. The case before this Court can and should be decided through application of the Administrative Procedure Act.

Respectfully submitted.

American Bar Association,
By Franklin M. Schultz,
Chairman, Administrative Law Section.
John T. Miller, Jr.,
Its Attorneys.

August, 1970.

APPENDIX A

Statutes Involved

1. The Social Security Act, as amended, 42 U.S.C.A. §§ 401, *et seq.*, provides in pertinent part:

> § 405(b) The Secretary is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this subchapter. Upon request by any such individual or upon

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[9] 92 Cong. Rec. 2157, March 12, 1946.
[10] S. Rep. No. 752, *supra*, 22–23.
[11] H. Rep. No. 1980, *supra*, 37.

request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, husband, widower, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Secretary has rendered, he shall give such applicant or such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision. * * * In the course of any hearing, investigation, or other proceeding, he may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Secretary even though inadmissible under rules of evidence applicable to court procedure.

* * * * * * *

§ 405(g) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow.

Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court shall, on motion of the Secretary made before he files his answer, remand the case to the Secretary for further action by the Secretary, and may, at any time, on good cause shown, order additional evidence to be taken before the Secretary, and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or its decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based.

Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

* * * * * * *

§ 421(a) In the case of any individual, the determination of whether or not he is under a disability (as defined in section 416(i) or 423(d) of this title) and of the day such disability began, and the determination of the day on which such disability ceases, shall, except as provided in subsection (g) of this section, be made by a State agency pursuant to an agreement entered into under subsection (b) of this section. Except as provided in subsections (c) and (d) of this section, any such determination shall be the determination of the Secretary for purposes of this subchapter.

* * * * * * *

§ 421(d) Any individual dissatisfied with any determination under subsection (a), (c), or (g) of this section shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

2. The Administrative Procedure Act, as amended, 5 U.S.C.A. §§ 551, *et seq.*, provides in pertinent part:

§ 554(a) This section applies, according to the provisions thereof, in every case of adjudication required by statute to be determined on the record after opportunity for an agency hearing, except to the extent that there is involved—

(1) a matter subject to a subsequent trial of the law and the facts de novo in a court;

(2) the selection or tenure of an employee, except a hearing examiner appointed under section 3105 of this title;

(3) proceedings in which decisions rest solely on inspections, tests, or elections;

(4) the conduct of military or foreign affairs functions;

(5) cases in which an agency is acting as an agent for a court; or

(6) the certification of worker representatives.

* * * * * * *

§ 556(d) Except as otherwise provided by statute, the proponent of a rule or order has the burden of proof. Any oral or documentary evidence may be received, but the agency as a matter of policy shall provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence. A sanction may not be imposed or rule or order issued except on consideration of the whole record or those parts thereof cited by a party and supported by and in accordance with the reliable, probative, and substantial evidence. A party is entitled to present his case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts. In rule making or determining claims for money or benefits or applications for initial licenses an agency may, when a party will not be prejudiced thereby, adopt procedures for the submission of all or part of the evidence in written form.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1970

No. 108

ELLIOT L. RICHARDSON, SECRETARY OF HEALTH,
EDUCATION, AND WELFARE, PETITIONER

v.

PEDRO PERALES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

We submit this reply brief to respond (1) to the contention of the *amicus curiae* American Bar Association that the Administrative Procedure Act, rather than the Social Security Act, establishes the procedure to be followed at administrative hearings of claims for disability benefits filed under the Social Security Act; and (2) to the contention of the respondent and the *amicus* Legal Aid Association that, in a variety of particulars, the hearing procedure by which disability claims are determined is invalid on due process grounds.

1. In our opening brief, we relied on the provisions of the Social Security Act and the regulations of the Secretary promulgated thereunder as validly authorizing the procedure presently utilized in the conduct of hearings of social security disability claims. The *amicus* American Bar Association contends, however, that the Administrative Procedure Act (5 U.S.C. 551, 556), rather than the Social Security Act, governs the conduct of hearings under the Social Security Act. The ABA recognizes that the two Acts do not conflict with respect to the issues now presented (Brief, p. 8), but expresses concern over "the complete denial of access to the rights assured by the APA implicit in" our argument (Brief, p. 5). As we show below, however, the broad question of the general applicability of the Administrative Procedure Act to hearings of disability claims under the Social Security Act is of no consequence here. For, assuming its applicability, the Administrative Procedure Act specifically authorizes the procedures which the Secretary follows under the Social Security Act. This is not surprising, since the Social Security Act furnished the model upon which the Administrative Procedure Act was based. See Final Report of the Attorney General's Committee on Administrative Procedure (reprinted as S. Doc. 8, 77th Cong., 1st Sess.), p. 157.

The section of the Administrative Procedure Act dealing with the procedure at hearings (5 U.S.C. 556) provides that "[a]ny oral or documentary evidence may be received" and, with particular significance here, that "[i]n * * * determining claims for money or benefits * * * an agency may, when a party will not be prejudiced thereby, adopt procedures for the submission of all or part of the evidence in written form." 5 U.S.C. 556(d). That same subsection also provides that "[a] party is entitled * * * to conduct such cross-examination as may be required for a full and true disclosure of the facts."[12]

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[12] In full, 5 U.S.C. 556(d) provides:

> Except as otherwise provided by statute, the proponent of a rule or order has the burden of proof. Any oral or documentary evidence may be received, but the agency as a matter of policy shall provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence. A sanction may not be imposed or rule or order issued except on consideration of the whole record or those parts thereof cited by a party and supported by and in accordance with the reliable, probative, and substantial evidence. A party is entitled to present his case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts. In rulemaking or determining claims for money or benefits or applications for initial licenses an agency may, when a party will not be prejudiced thereby, adopt procedures for the submission of all or part of the evidence in written form.

Taken together, these provisions confirm, rather than supersede, the authority given to the Secretary by the Social Security Act. They are, in effect, an additional authorization of the procedures adopted by him.

Thus, in specifically authorizing an agency "determining claims for money or benefits" to "adopt procedures" for the submission of evidence in written form, the Administrative Procedure Act leaves standing the power vested in the Secretary by the Social Security Act to "establish procedures" and "provide for the nature and extent of the proofs and evidence" (42 U.S.C. 405(a)) free from the "rules of evidence applicable to court procedure" (42 U.S.C. 405(b)). Moreover, while the Administrative Procedure Act limits the exercise of the authority to receive evidence in written form to circumstances in which a party "will not be prejudiced thereby," and preserves a party's right to conduct such cross-examination "as may be required for a full and true disclosure of the facts," the procedures established by the Secretary accord full recognition to, and are fully consistent with, those limitations. Specifically, as we explained in our opening brief, the Secretary's regulations permit the introduction of written medical reports while preserving the right of cross-examination "[w]hen reasonably necessary for the full presentation of a case." 20 C.F.R. 404.926.

Consequently, as the American Bar Association's brief recognizes, the Secretary's exercise of his authority under the Social Security Act does not conflict with the provisions of the Administrative Procedure Act. While the court below held the Administrative Procedure Act inapplicable to the conduct of hearings under the Social Security Act on the ground that 5 U.S.C. 556(b) states that the entire administrative procedure subchapter (5 U.S.C. 551–559) "does not supersede the conduct of specified classes of proceedings, in whole or in part by or before boards or other employees specifically provided for by or designated under statute" (App. 42), there is no occasion for this Court here to consider the correctness of that broad ruling.

2. The respondent asserts (Brief, pp. 23–27) that hearing examiners function both as judges and as counsel for the Social Security Administration with "the responsibility of * * * seeking to make the Government's case as strong as possible" (Brief, p. 25). He then argues that claimants are thereby denied a fair hearing of their disability claims and that a modification of the presnet procedure to provide for the appointment of an independent hearing examiner is necessary.

We note, first, that this contention seeks relief in addition to, and of a different character from, that awarded the respondent by the court of appeals. Since respondent did not file a cross-petition for a writ of certiorari on this issue, and since this question is not fairly encompassed within the grant of certiorari, it is not properly before this Court. *Radio Officers* v. *National Labor Relations Board*, 347 U.S. 17, 37 n. 35.

At all events, respondent's argument is based on an erroneous conception of the role of the hearing examiner. Although hearing examiners function as judges, they do not act as counsel for the government. Their role is not to gather evidence in support of the "government's case," but to develop all the relevant evidence bearing on the claimant's condition, whether favorable or unfavorable, so that all the facts are before them when they make their decision. The basic fairness of this system is shown by the statistic, relied on by the *amici* Appalachian Research Fund et al. (Brief, p. 23), that hearing decisions—which almost exclusively concern only those cases in which the state agency did not grant benefits (see 42 U.S.C. 421(c))—favor claimants 44.2 percent of the time.[13]

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[13] The respondent seems to seek, in place of the present informal system, a full-blown adversary procedure. For if there were an "independent hearing examiner" who would not gather evidence, there would necessarily also have to be a government attorney who would attempt to develop evidence to disprove the claim. (Hearings of claims under the Longshoremen's and Harbor Workers' Compensation Act, which the respondent believes provide an appropriate procedure, involve competing presentations by the claimant and the employer or its insurer and result, when the employee prevails, in a judgment against the employer or its insurer.) The establishment of such a procedure, whereby competing presentations would be made by the claimant on the one hand and by the government on the other, would scarcely be beneficial to claimants, many of whom are not represented by counsel, and would add substantially to the administrative costs borne by the trust fund. Most importantly, it would be contrary to the congressional intent to provide a simple procedure whereby claimants can establish their right to benefits.

Respondent's reliance on *Goldberg* v. *Kelly*, 397 U.S. 254, is misplaced. *Goldberg* involved the termination of welfare benefits in circumstances in which the claimant was completely foreclosed both from making an oral presentation and from confronting or cross-examining adverse witnesses. Against that background, and in circumstances "where credibility and veracity are at issue" (397 U.S. at 269), this Court required that the claimants be given the "effective opportunity" to confront any adverse witnesses (397 U.S. at 268).

The situation here is entirely different. In the first place, written medical reports do not ordinarily involve questions of credibility and veracity. Even more important, the reports are disclosed to the claimants who are then presented with the "effective opportunity" through the use of a subpoena to cross-examine their authors. All that is required is that the claimant exercise that opportunity by stating reasons why, in the particular case, cross-examination is needed. In these circumstances, the court below correctly held that the claimant could not complain of the "denial" of the right to cross-examination when he had failed to take the steps required to implement that right (App. 43–44). For the reasons stated in our opening brief, however, it should also have held that the reports, even though technically "hearsay," can constitute a sufficient basis for an administrative determination when their content warrants it.

Respectfully submitted.

ERWIN N. GRISWOLD,
Solicitor General.
L. PATRICK GRAY III,
Assistant Attorney General..
DANIEL M. FRIEDMAN,
Deputy Solicitor General.

JANUARY 1971.

Excerpt From *Richardson* v. *Perales*, 402 U.S. 410 (1971)

* * * * * * *

4. Finally, the claimant complains of the system of processing disability claims. He suggests, and is joined in this by the briefs of *amici*, that the Administrative Procedure Act, rather than the Social Security Act, governs the processing of claims and specifically provides for cross-examination, 5 U.S.C. § 556(d). (1964 ed., Supp. V). The claimant goes on to assert that in any event the hearing procedure is invalid on due process grounds. He says that the hearing examiner has the responsibility for gathering the evidence and "to make the Government's case as strong as possible"; that naturally he leans toward a decision in favor of the evidence he has gathered; that justice must satisfy the appearance of justice, citing Offutt v. United States, 348 U.S. 11, 14, 75 S. Ct. 11, 13, 99 L. Ed. 11 (1954), and In re Murchison, 349 U.S. 133, 136, 75 S. Ct. 623, 99 L. Ed. 942 (1955); and that an "independent hearing examiner such as in the" Longshoremen's and Harbor Workers' Compensation Act should be provided.

We need not decide whether the APA has general application to social security disability claims, for the social security administrative procedure does not vary from that prescribed by the APA. Indeed, the latter is modeled upon the Social Security Act. See Final Report of the Attorney General's Committee on Administrative Procedure, contained in Administrative Procedure in Government Agencies, S. Doc. No. 8, 77th Cong., 1st Sess., 157 (1941); see also the remarks of Senator McCarran, chairman of the Judiciary Committee of the Senate, 92 Cong. Rec. 2155. The cited § 556(d) provides that any documentary evidence "may be received" subject to the exclusion of the irrelevant, the immaterial, and the unduly repetitious. It further provides that a "party is entitled to present his case for defense by oral or documentary evidence * * * and to conduct such cross-examination as may be required for a full and true disclosure of the facts" and in "determining claims for money or benefits * * * an agency may, when a party will not be prejudiced thereby, adopt procedures for the submission of all or part of the evidence in written form."

[4] These provisions conform, and are consistent with, rather than differ from or supersede, the authority given the Secretary by the Social Security Act's §§ 205 (a) and (b) "to establish procedures," and "to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits," and to receive evidence "even though inadmissible under rules of evidence applicable to court procedure." Hearsay, under either Act, is thus admissible up to the point of relevancy.

* * * * * * *

G. THE GROWING IMPACT OF SOCIAL SECURITY DISABILITY LITIGATION

The number of Social Security cases which are appealed to the courts have been steadily increasing. The first sizable flow of the Supplemental Security Income (SSI) cases will soon reach the judicial review stage and a large, but undetermined, number of Black Lung cases will also be appealed to the courts. In this section, attention will be placed both on the workload aspects and the degree of success claimants experience in an appeal to the judiciary. In both instances, there seems to be very substantial variance from court to court and Circuit to Circuit. This section will also deal with the question of the time burden placed on the claimant and point out, briefly, how such cases affect the overall workload of the Federal Judiciary.

CASELOAD

In fiscal 1960, 618 social security cases were filed in District Courts; in fiscal 1973, 2,267 were filed. Disability filings for the last quarter of 1972 were 444. They had increased to 631 for the third quarter of 1973. The great majority of Social Security cases (75 to 80 percent) are disability claims. The following table shows the growth in terms of pending cases at the end of the fiscal year:

TABLE 1.—*End-of-year growth in pending cases* [1]

Calendar year	Total social security cases	Disability cases
1960	337	
1968	1, 751	1, 307
1969	2, 370	1, 748
1970	2, 769	2, 001
1971	3, 148	2, 251
1972	3, 775	2, 676
1973	4, 033	3, 018
1974 (June 17)	4, 708	4, 187

[1] These statistics have been supplied by the Office of General Counsel. 384 Black Lung cases were also pending on June 17, 1974.

The statistics of the Administrative Office of the U.S. Courts for fiscal 1973 shows a median time for disposal of social security cases of 10 months, with 10 percent of the cases disposed in 3 months and, at the other extreme, 10 percent requiring 29 months (Annual Report, p. A–28). Perhaps related to these statistics are those of the backlog of cases facing social security and regional attorneys. As of December 31, 1973 there were about 635 Social Security cases awaiting the preparation of the Government's brief and, on the average, 96 days had elapsed since the case had been assigned to attorneys for preparation. Moreover, in region I (New England) the figure was 149 days and region IV (Midwest) the figure was 181 days.[1]

Social Security court workload is very uneven throughout the country. More claimants seem to apply for benefits [2] and to appeal denials with more frequency in certain parts of the country than in others. For instance of the

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[1] The regional variations are complicated by the situation that some Courts have set time limits within which the Government must file answers, motions, and briefs. To meet the deadlines imposed by these not necessarily unreasonable judicial demands, the work on briefs is further delayed in other jurisdictions.

[2] See chart showing major variation between State and regions in percentage of population receiving disability benefits, p. 329.

2,595 [3] pending social security cases at the end of fiscal 1973, 887 (34 percent) were before the following five District Courts:

Puerto Rico	252
South Carolina	182
West Virginia-southern	111
Kentucky-eastern	297
Kentucky-western	42

The jurisdictions noted account for considerably less than 10 percent the disabled workers receiving benefits, even though all these jurisdictions have an extremely high incidence of disability compared to the national average. Interestingly enough these jurisdictions also have some of the highest State agency denial rates, but as we will note in the next section, their court reversal rates vary markedly. A study of the interrelationship and possible correlation of these various aspects of the program might produce some interesting insights into the program. The area seems relatively unexplored.

In terms of court workload by Circuit the same disparity exists. The 4th and 5th Circuits have had 47 percent of all the disability court cases. The 4th, 5th, and 6th Circuits taken together have had 69 percent of the cases and they will be even harder hit when the Black Lung cases mature. On the other hand, New York and California which have had roughly 20 percent of the disability caseload have had only 6 percent of the court cases.

REVERSAL RATES

It appears logical to suppose that claimants appeal social security cases because of the relatively high likelihood of success. The latest statistics show that the Department is being reversed in over half the cases which go to hearings before Administrative Law Judges. Although the ALJ reversal rates have been going up rather steeply, the Court reversal rates have been going down. Back in the fifties and sixties the Courts were reversing the Department at a rate [4] which, at times, was considerably over 50 percent and stood at 52 percent for the overall period of 1955–67. In recent years there has been a slow but steady decline in the rate until now the Government is being reversed in only about 30 percent of the cases.

The net effect of the increasing administrative hearing reversal rate and declining court reversal rate has been a higher allowance rate for individuals who have decided to take their cases to hearings. This is true because more cases go to hearings and, therefore, changes in the reversal rate at this level are more significant statistically. For instance in 1960, 3,470 (17 percent) of the 20,262 claimants who went to hearings ultimately were awarded benefits. In fiscal 1973, 33,906 (34.4 percent) of 68,356 claimants who went to hearings got benefits. As with so many of the statistics in the disability program, the reversal rate varies rather widely among district courts throughout the country.

Looking at the unadjusted nationwide court reversal rate,[5] it is 26 percent cumulatively through September 1973 for all the years of the disability program. By circuit, however, there is a much more varied picture. The 1st and 2d Circuit have reversal percentages of 7 percent and 8 percent respectively, but the 4th Circuit has one of 40 percent. For individual District Courts, they vary much more markedly—from a zero reversal rate in Wyoming (involving only one case which was upheld) to a 56 percent rate in South Carolina (405 reversals out of 712 cases). Moreover, 1,128 of the total of 2,046 reversals (55 percent) were in the 4th and 5th Circuits which are made up of Maryland, North Carolina, South Carolina, Virginia, West Virginia, Alabama, Florida, Georgia, Louisiana, Mississippi, and Texas.

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[3] Administrative Office of the U.S. Court. These statistics vary somewhat from HEW reports but the relative distributions are approximately the same.

[4] The reversal rate referred to here is the cumulative rate which includes allowances after Court remands are taken into account.

[5] In these statistics the Court remand cases which were eventually allowed have not been included.

IMPACT ON JUDICIARY

Finally, there is the question of the effect on the Federal court system of a growing disability caseload which will be greatly accelerated in the next few years by Black Lung appeals and, more importantly over the long run, by cases coming up under the Supplemental Security Income program.

It can be argued that in the recent past the impact of Social Security was not particularly significant in that it constituted, as late as fiscal 1973, only 2.5 percent of Federal District Court civil filings. Pursuing this line of argument, it could also be noted that although the number of cases may be large, they are nearly all decided on motions for summary judgment and presumably take relatively little of the court's time.[6] It might also be pointed out that the volume of Social Sercurity disability litigation in fiscal 1973 was only twice that arising under the Federal Employers' Liability Act (applicable to about three-quarters of a million railroad employees) and only slightly more than half of the number of cases filed under the Jones Act (applicable to a million seamen).

On the other hand, these latter statutes are not analogous to the Social Security, SSI, and Black Lung programs with their many layers of administrative review nor do they have the potentialities for growth of the latter. If filings increase in the manner which is presently estimated (to about 10,000 cases in 2 or 3 years) and assuming all civil filings stay in the neighborhood of 100,000 a year (as they have done in fiscal years 1971–73) then the Social Security, SSI, and Black Lung cases will constitute 10 percent of all civil filings.

Obviously, the impact of the social security disability caseload on various courts in the country is uneven and, undoubtedly, will be of crisis proportions in certain judicial districts in the next few years. For instance, in the 2d and 10th Circuit social security cases constituted only 1 percent of civil caseloads; but in the 4th Circuit they made up 5 percent. In the District Court for Eastern Kentucky they were 22 percent of the civil caseload.

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[6] This means that there are no jury trials which may be time consuming. On the other hand, the examination of the often voluminous record in disability cases can be time consuming and most cases require written opinions of substantial length.

H. SUBSTANTIAL EVIDENCE RULE

The Social Security Administration and others have long complained that many courts have shown a lack of restraint in substituting their judgment of the facts for those of the administrative adjudicators—that they have all too often disregarded the substantial evidence rule.

In 1960 the Harrison Subcommittee took the position that the manner in which the courts were treating the substantial evidence rule might be related to whether they felt the claimant was receiving a fair hearing. The report stated:

> * * * During the course of the hearings held by the subcommittee, concern was voiced as to whether the courts were violating the rule by undertaking to make independent judgments as to the balance of the evidence in disability cases.
>
> * * * * * * *
>
> The jurisdiction of a court to review a determination of the Secretary is limited to a review of the record made before the Secretary. It is not a trial de novo but is limited to a consideration of the pleadings and the transcript of the proceedings at the hearing. The court has no power to hold a hearing and determine the merits of the claim because the statute makes it clear that the determination of claims is solely a function of the Secretary.
>
> Sections 216 and 223 of the Social Security Act require that claimants establish the existence of disability by such proofs as the Secretary may prescribe. The Secretary has not seen fit, however, to publish these requirements in the form of regulations to any degree. In contrast to the detailed regulations pertaining to the establishment of regular old-age and survivors insurance claims, the disability regulations (20 CFR 401.1501) state only that impairment must be shown by "medical evidence, and where necessary by appropriate medical tests." Although the confidential manual specifies the tests which are deemed appropriate, the instances in which they are necessary, states that the evidentiary requirements are not met by submission of opinions by doctors on the ultimate issue of disability, these materials are not available to the claimants and the courts. Even these guides do not spell out the types of evidence, if any, which should be submitted in order to prove the existence of the so-called "nonmedical" factors. Looking at the situation in this context, some of the courts which seem to be relaxing the "substantial evidence" rule, may, in reality, be wrestling with the problem of insufficient regulations as to burden the proof (pp. 41–42).[1]

The appendix to this section contains a paper prepared in 1963 by the G. W. Law Group summarizing the case law prevailing at that time. There does not seem to have been any appreciable change in terms of the problems presented by the case law which prevails today on the substantial evidence rule.

The problems that exist with respect to the application of the rule have not abated. In the only Supreme Court case which concerned a major element of the disability program the Court was on the periphery of the "substantial evidence rule" and was dealing specifically with the question of the evidential worth of consultative examinations. It held in *Richardson* v. *Perales*, 402 U.S. 389 (1971), that written reports by physicians who examined the claimant could constitute "substantial evidence" in denying a claim notwithstanding the report's hearsay character, the absence of cross-examination (through claimant's failure to exercise his subpoena rights in the Court's view), and the contrary live testimony of the claimant's doctor.

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[1] Since the Harrison Subcommittee consideration, the SSA has issued more detailed regulations, particularly in the medical standards areas. The Harrison Subcommittee had also called for greater development of the nonmedical standards in the regulatory material since these nonmedical aspects are involved in the borderline cases which make up the bulk of those which are appealed.

The Court's general statement was that it had considered the rule:

> * * * in other, yet similar, contexts. The National Labor Relations Act. Section 10(e), in its original form, provided that the NLRB's findings of fact "if supported by evidence, shall be conclusive." 49 Stat. 454. The Court said this meant "supported by substantial evidence" and that this was "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Consolidated Edison Co.* v. *NLRB*, 305 U.S. 197, 229, 59 S. Ct. 206, 217, 83 L.Ed. 126 (1938).
>
> The Court has adhered to that definition in varying statutory situations. See *NLRB* v. *Columbian Enameling & Stamping Co.*, 306 U.S. 292, 300, 59 S. Ct. 501, 505, 83 L. Ed. 660 (1939); *Universal Camera Corp.* v. *NLRB*, 340 U.S. 474, 477–487, 71 S. Ct. 456, 459–464, 95 L.Ed. 456 (1951); *Consolo* v. *Federal Maritime Commission*, 383 U.S. 607, 619–620, 86 S. Ct. 1018, 1026–1027, 16 L.Ed. 2d 131 (1966)

Dixon, like the Harrison Subcommittee, concludes that problems with the substantial evidence rule may involve issues broader than the rule itself. He writes:

> The degree to which a limited review-substantial evidence rule will be followed by the courts may well be a function not of the rule itself but of the degree of (a) judicial acceptance of the goals of the political branches as embodied in the program, (b) the clarity of the statutory-administrative standards, and (c) the precision in administrative procedures and operational criteria for applying the standards. If so, the SSA disability program, despite the 1967 amendments, may fail to command judicial credibility on point (a), defies credibility on point (b), and may still be in trouble on point (c), as necessarily interrelated with point (b). Hence, the present degree of judicial acceptance of the 1967 amendments and the favorable Perales opinion may be only a lull induced more by the magnitude of the program and a sense of its administrative impossibilities than by any acceptance of the program in principle (p. 102).

Dean Mayo of George Washington Law Group writing earlier also viewed the "substantial evidence rule" in a broader context seeing the highly individualized disability determination process without adequate standards and consistent methodology of adjudication as inviting wide variations in how the "rule" would be applied. He maintained that "the crux of the problem is the specification of a criterion or criteria of decision which will translate the Substantial Evidence Rule into an operationally measurable standard" (pt. II, pp. 1–108). Without this, he wrote, the rule "if not completely meaningless in many instances . . . is not sufficiently sharp to provide an intelligible criterion of decision in the bulk of the marginal cases submitted to court review." He describes some of the approaches widely used by the Courts:

> When, after a summary discussion of the facts relating to impairment, the mere assertion that there is or is not sufficient evidence to satisfy the Substantial Evidence Rule obscures the actual process of decision, assuming that there has been some conscious attempt to define more precisely the standard represented by the Rule, though not explicitly stated in the opinion, rather than a wholly impressionistic judgment by the court. Sometimes a feeble effort is made to render the Rule more explicit as a criterion of decision by indicating that the Rule requires "some evidence" supporting the position of the Secretary or "more than a scintilla," or "sufficient evidence from which a rational conclusion might be drawn." Occasionally the judgment appears to be made on the basis of a "preponderance" of the evidence which is an imprecise balancing approach. It must be said for those courts which actually define the criterion as in terms of "any" or "some" evidence supporting the Secretary's determination

> that it does provide a basis for consistent mechanical application. Certain courts do get much more explicit in their definition of operational criteria as was the situation in *Kerner*. A rare few occasionally present a well-structured, systematic process of decision including satisfactory operational criteria which place the whole process on an explicit, objective basis.
>
> * * * * * * *
>
> The conclusion inevitably follows that a simple, mechanical formula cannot define the type, quantum and quality of evidence that will satisfy the Rule for any and all courts, not even in the severely restricted context of Social Security disability determinations. In sum, one must look to particular courts or to groups of courts entertaining similar disability concepts, applying similar decisional models and operational criteria, and requiring similar levels of evidential support in order to predict with any degree of reliability what evidence will satisfy the Rule (pt. II, pp. 1–110).

Professors Davison and Goldsborough of the G.W. Law group wrote that *if* the appropriate development is present the Court may give substance to the rule:

> Given a scheme of review which presents comprehensive records developed in an objective "hearing," the courts will be prone to grant appropriate deference to agency "expertise" and to adopt as a formula of review the following classic statement from *Scott* v. *Ribicoff* (N.D. La., July 20, 1962 (unreported). "Keeping in mind that substantial evidence requires only such relevant evidence as a reasonable mind might accept as adequate to support a conclusion, let us consider what evidence was available to the hearing examiner upon which he based his conclusions" (pt. II, pp. 2–27).

In answer to a staff question as to what are the problems in the area of judicial interpretation, the Social Security Administration has written: "While no real problem is presented, some courts continue to place great weight on subjective complaints and make independent evaluations of the evidence not in keeping with the 'substantial evidence' rule." In discussing their criteria for appeal, the Social Security Administration states:

> The fact that the court had readjudicated the case on the evidence of record is usually not a basis for a recommendation to seek appellate review, even where the court seems to have disregarded the substantial evidence rule. Appeal is recommended in cases where serious program implications and a strong factual record exists.

The staff is not altogether convinced that chronic disregarding of the substantial evidence rule does not have "serious program implications" and that ignoring these District Court cases is a policy which should be pursued. The preceding commentary acknowledges the difficulty in dealing with the situation, but the staff believes that the Social Security Administration has an obligation of candidly presenting to the Committee an outline of the basic problem. If it turns out to be one where lack of judicial restraint is the primary element, perhaps the Judicial Conference or other scholars on the judiciary can be consulted on appropriate remedial action. Commentators have noted the propensity of the courts to examine *de novo* those areas where they believe they have more expertise. Thus, courts may be more likely to look closely at disability cases than the cases from regulatory agencies which have complex economic issues. On the other hand, if the problem turns out to be primarily one of lack of judicial confidence in the Social Security appeal mechanism, or the lack of adequate definitional criteria, this conclusion should be communicated to the Committee. The amount of Social Security disability litigation alone would appear to justify this scrutiny.

The uncertainty of how the Supplemental Security Income (SSI) review criteria will be applied makes it even more compelling that these questions be answered to the fullest extent possible. For it was the clear intention of Congress that in reviewing SSI appeals the courts are to have no authority to question the Secretary's determination as to any fact in arriving at a decision.

In place of the substantial evidence rule, the SSI provision (sec. 1631(c)(3)) states that:

> * * * the final determination of the Secretary after a hearing. . . . shall be subject to judicial review as provided in section 205(g) to the same extent as the Secretary's final determination under section 205; except that the determination of the Secretary after such hearing as to any fact shall be final and conclusive and not subject to review by any court.

It remains to be seen, however, whether this will have any appreciable impact on how Courts will deal with SSI disability cases as opposed to Social Security disability cases. Justice Frankfurter stated in the *Universal Camera* case:

> Since the precise way in which courts interfere with agency findings cannot be imprisoned within any form of words, new formulas attempting to rephrase the old are not likely to be more helpful than the old. There are no talismanic words that can avoid the process of judgment. The difficulty is that we cannot escape, in relation to this problem, the use of undefined defining terms (340 U.S. 474, 488–489).

APPENDIX

Excerpt from the National Law Center of George Washington University, "The Social Security Administration: An Inter-Disciplinary Study of Disability Evaluation," pt. II, *The Judicial Concept of Disability Under the Social Security Act.*

SCOPE OF JUDICIAL REVIEW

Judicial review of the final decision of the Secretary is circumscribed by statutory and case law. The statutory scope of judicial review of determinations made by the Secretary under the Social Security Act is delineated in section 405(g), title 42, U.S.C., which states, in pertinent part, that:

> The Court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a hearing. The findings of the Secretary as to any fact, *if supported by substantial evidence*, shall be conclusive, * * *.

Thus, the reviewing authority of the courts is limited by this rule.

However, as Mr. Justice Frankfurter observed in *Universal Camera Co.* v. *N.L.R.B.*, 340 U.S. 474, 488:

> * * * A formula for judicial review of administrative action may afford grounds for certitude but cannot assure certainty of application.

How precise the standard made applicable to the findings of the Secretary under the Social Security Act is, and how well it is applied in practice, is the question that this annotation will consider, with reference to the decided cases of current significance.

I. DERIVATION OF THE RULE

The development of many new regulatory controls and new forms of social legislation by the U.S. Government in the period of legislative activity in the 1930's under the administration of Franklin Roosevelt, brought up the question of how far the reviewing courts could review and set aside administrative fact/law determinations. The statutes have generally provided that findings of fact should be based on "evidence" in the record, or on "substantial evidence". The courts in reviewing the adjudicatory proceeding of these new agencies interpreted the requirement of evidence to be coextensive with "substantial evidence," whether or not the word "substantial" was used in the statute, although the Supreme Court has expressly held that "substantial evidence" is not a larger quantity than "any evidence." [1] However, "substantial evidence" was held to mean more than a mere scintilla; it ". . . means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." [2]

But, as Justice Frankfurter observed in *Universal Camera:*

> The very smoothness of the "substantial evidence" formula as the standard for reviewing the evidentiary validity of the Board's findings established its currency. But the inevitably variant applications of the standard to conflicting evidence soon brought contrariety of views and in due course bred criticism.

Under the application of the standard then current, the courts read only one side of the case and, if they found evidence there, sustained the administrative determination and ignored the record to the contrary. Congress ultimately found it necessary to provide a new and stronger standard for judicial review, and in 1946 passed the Administrative Procedure Act, 5 U.S.C.A. section

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[1] *Del Vecchio* v. *Bowers*, 296 U.S. 280, 56 S. Ct. 190 (1935).

[2] *Consolidated Edison Co.* v. *NLRB*, 305 U.S. 197, 59 S. Ct. 206 (1938).

1001, et seq., to provide for judicial review of the action of administrative agencies. Section 10(e) of that Act (5 U.S.C.A. sec. 1009) declares:

> So far as necessary to decision and where presented the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of any agency action. It shall * * * (B) hold unlawful and set-aside agency action, findings, and conclusions found to be (1) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; * * * (3) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; * * * (5) unsupported by substantial evidence in any case * * * reviewed on the record of an agency hearing provided by statute; * * *. In making the foregoing determinations the court shall review the whole record or such portions thereof as may be cited by any party, and due account shall be taken of the rule of prejudicial error.

Thus, to the standardized phrase "substantial evidence," were added two standardized words enlarging that phrase to "substantial evidence upon the *whole record.*"

The provisions of Section 10 of the Administrative Procedure Act have been construed to be in *pari materia* with those of the Social Security Act. See *Goldman* v. *Folsom*, 246 F. 2d 776 (1957); *Rafal* v. *Flemming*, 171 F. Supp. 490 (1959); *Julian* v. *Folsom*, 160 F. Supp. 747 (1958).

The Administrative Procedure Act became the subject of litigation which led to an authoritative pronouncement by the Supreme Court of the United States. The case of *Universal Camera Co.* v. *N.L.R.B.*, 340 U.S. 474 (1950) formulated the new "whole record" rule restating the quantum of evidence required to support administrative adjudication.

Mr. Justice Frankfurter at p. 488 of 340 U.S. said:

> To be sure the requirement for canvassing "the whole record" in order to ascertain substantiality does not furnish a calculus of value by which a reviewing court can assess the evidence. Nor was it intended to negative the function of the Labor Board as one of those agencies presumably equipped or informed by experience to deal with a specialized field of knowledge, whose findings within that field carry the authority of an expertness which courts do not possess and therefore must respect. Nor does it mean that even as to matters not requiring expertise a court may displace the Board's choice between two fairly conflicting views, even though the court could justifiably have made a different choice had the matter been before it *de novo*. Congress has merely made it clear that a reviewing court is not barred from setting aside a Board decision when it cannot conscientiously find that the evidence supporting that decision is substantial, when viewed in the light that the record in its entirety furnishes, including the body of evidence opposed to the Board's view.

Clearly, then, the substantiality of evidence must take into account whatever in the record fairly detracts from its weight.

In this same opinion, Mr. Justice Frankfurter also set forth some cautions and reservations when he considered the applicability of the formula to all situations as a clear and objective guide.

Thus he said on pp. 488–9 of 340 U.S.:

> * * * Some scope for judicial discretion in applying the formula can be avoided only by falsifying the actual process of judging or by using the formula as an instrument of futile casuistry. *It cannot be too often repeated that judges are not automata.* [Italics supplied.] The ultimate reliance for the fair operation of any standard is a judiciary of high competence and character and the constant play of an informed professional critique upon its work.
>
> Since the precise way in which courts interfere with agency findings cannot be imprisoned within any form of words, new formulas attempting to rephrase the old are not likely to be more helpful than the old. There are no talismanic words that can avoid the process of judgment. The difficult is that we cannot escape, in relation to this problem, the use of undefined defining terms.

He also demonstrated in the two companion cases decided by the Supreme Court at the same time as the *Universal Camera Co.* case, that he had difficulty with the formula. In the one case, *N.L.R.B.* v. *Pittsburgh Steamship Co.*,[3] the Court upheld the determination of the Court of Appeals that the Board finding was not supported by substantial evidence in the record as a whole, even though at the same time the Supreme Court indicated it might itself have reached a different result had it been the reviewing court. In the other case of *O'Leary* v. *Brown-Pacific-Maxon*,[4] the Supreme Court reversed the Court of Appeals by finding that the opinion of the Deputy Commissioner was in fact supported by substantial evidence in the record as a whole. It now seems clear that there was no factual basis for the Commissioner's ruling. Rather it was a liberal or extensive interpretation of the law of a remedial statute, with the facts "found" quite unsupported by evidence in the record as a whole. Mr. Justice Frankfurter's admonitions in the *Universal Camera* case that the standard had many subjective qualities was fully demonstrated in these three cases.

II. THE SUBSTANTIAL EVIDENCE RULE

The limited scope of judicial review under Section 405(g) of Title 42 U.S.C., i.e., the Social Security Act, is intended to act as a restriant on the reviewing courts. Thus, they may not substitute their own factual findings for those of the Secretary.[5] The statute provides that such findings are "conclusive", but that statement must always be taken subject to the qualification "if supported by substantial evidence," since in the absence of such evidence there is an error of law,[6] and the court, without disturbing the Secretary's absolute pre-eminence in the realm of fact-finding, can still reverse for legal error.

The finality accorded to administrative findings of fact also extends to inferences and conclusions drawn by the Secretary if there is a substantial basis for them.[7]

For instance, in cautioning district courts against the substitution of their inferences or those of the agency (Secretary), the Second Circuit in *Walker* v. *Altmeyer*, 137 F. 2d at 533–534 said:

> The error into which the court fell was not that of making new and contrary findings but that of substituting new and contrary inference[s] of its own from the found facts which led it to reverse the administrative conclusion which had been reached * * *. That sort of action went beyond the power of the district court to review in such a suit as this. It was the judgment of the administrative body * * * rather than that of the court which the statute made effective provided that judgment was based upon conclusions reasonably reached upon due consideration of all relevant issues presented after parties in interest had been given a fair hearing or a fair opportunity to be heard upon the facts and the applicable law. *Gray* v. *Powell*, 314 U.S. 402, 62 S. Ct. 326, 86 L. Ed. 301.

The Social Security Act contains a definition of the degree of disability which must be established in a record to support an allowance of benefits. The standard is defined in Section 416(i)(1) of Title 42 U.S.C. as "an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which may be expected to result in death or to be of long-continued and indefinite duration. * * *"[8] The application of this phrase is a question of law in each case. The rulings on this last issue are the "ultimate findings" to be supported by "substantial evidence in the record as a whole," a mixed law/fact question.

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[3] 340 U.S. 498 (1950).

[4] 340 U.S. 504 (1950).

[5] *Boyd* v. *Folsom*, 257 F. 2d 778, 781 (1958).

[6] *Crowell* v. *Benson*, 285 U.S. 22 (1932).

[7] *Rosewall* v. *Folsom*, 239 F. 2d 724 (1957); *Ferenz* v. *Folsom*, 23[illegible] F. 2d 46 (1956); *Livingstone* v. *Folsom*, 234 F. 2d 75 (1956). The general rule is stated in *U.S.* v. *LaLone*, 152 F. 2d 43, 44:

> This same finality [that extends to findings of fact] extends to the Board's inferences and conclusions from the evidence if a substantial basis is found for them * * *.

[8] This provision has been amended since publication of the G.W. study.

The Court in *Lynch* v. *Ribicoff* [9] recently had occasion to elaborate on the *whole record* rule as follows:

> The substantial evidence relied on by the hearing examiner to support his conclusions must be sufficiently persuasive to induce giving it the evidence and weight essential to support his findings. It must have these characteristics to such an extent that in the setting of the entire record, the Court may reasonably find in accordance with the hearing examiner's conclusion after giving due consideration to whatever else is shown, both in opposition in accord.

In the more complex cases, the number and inter-relation of the elements of proof essential to the administrative findings of fact became significant.[10] In *Underwood* v. *Ribicoff* [11] (a case which now stands as a landmark decision) the Fourth Circuit announced that:

> * * * there are four elements of proof to be considered in making a finding of Claimant's ability or inability to engage in any substantial gainful activity (and of which the court must find substantial evidence in the record). These are: (1) the objective medical facts, which are the clinical findings of treating or examining physicians divorced from their expert judgments or opinion as to the significance of these clinical findings, (2) the diagnoses, and expert medical opinions of the treating and examining physicians on subsidiary questions of fact, (3) the subjective evidence of pain and disability testified to by Claimant, and corroborated by his wife and his neighbors, (4) Claimant's educational background, work history, and present age.

All of the *Underwood* factors are relevant to statutory "disability" under the Act. And since the Act does not require *an absolute*, i.e., a bed-ridden, physical and mental incapacity to be established, the something less to gain disability status, becomes therefore a personal subjective matter after considering all the evidence set forth in the four categories.[12]

Thus the courts do not use the purely objective criteria in determining whether the Secretary's order dismissing the disability claim is supported by substantial evidence. It is a complicated law/fact/policy issue in which human capabilities and mental attitudes cannot be measured by objective guide posts as to values. The court, however, went on to observe in *Underwood* that:

> If there is only a slight preponderance of the evidence on one side or the other, the Secretary's finding must be affirmed.

But even where the reviewing court is strongly conscious of the substantial evidence restraints in considering the fourth *Underwood* item, a law/fact issue of a subjective nature becomes a policy issue, and "an ultimate fact" under the Act, as much as a simple evidential test. The courts so far have declined, by a legal analytical conception, to separate the review of substantial evidence from the remedial policies presumed to be intended by the basic legislation. A review of the collected Social Security cases to date suggests that, with some significant exceptions, reviewing courts—in their review of the ultimate fact determination—have applied the law both as to the remedial policy of the Act as well as to the legal sufficiency of the evidence in the record as a whole. The net effect is an independent review of the determination of ultimate facts.[13]

How has the influence of the subjective element contributed to the confusion in the application of the substantial evidence rule to the judicial review of cases arising under the Social Security Act?

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[9] U.S. District Court, S. Dist. of Illinois, S. Div. Civ. No. 2902, Dec. 11, 1962.

[10] A separate annotation entitled "Elements of Proof" will be found in this study.

[11] 298 F. 2d 850, 851 (CA4, 1962).

[12] *Butler* v. *Flemming*, 288 F. 2q 591, 595 (CA–5 1961):

> Considering the background, experience, training, education, physical and mental capacities of the claimant, the kinds and types of employment formerly followed and no longer open to him, the absence of any indication of any specific work less exacting within his residual competency and reasonably available as a prospective source of employment in the general area where he lives, this record satisfied the test. When the claimant could no longer shuffle dominoes he was not required by the use of a catalogue of the nation's industrial occupations to go down the list and wholly negative his capacity for each of them or their availability to him as an actual opportunity for employment.

[13] *Boyd* v. *Folsom*, 257 F. 2d 778, 781, (CA–3 1958); *Flemming* v. *Booker*, 283 F. 2d 321, 325 (CA 1960).

III. THE SUBJECTIVE ELEMENT

It is the subjective element, which the judge considers when he makes the ultimate fact determination, applying the law to the evidence before him, which enables him to give vent to the conflicts of justice in his reasoning. He contrasts the limited definition and holding on disability with the equities of the difficult human problems he and the claimants face together, the admitted relativity of the issue of disability and the need to consider age, education and past experience, in the light of the known unemployment difficulties of persons over 40 and particularly for those in their late 50's or early 60's. The Judge seeks a just or fair resolution of all these conflicts and is not therefore much concerned with the judicial self-limitation formula he should apply. He rejects the sterile limitations of judicial self-restraint in the technical formula that he must uphold findings of fact which are supported in the substantial evidence in the record as a whole.

For instance, in *Underwood* v. *Ribicoff*,[14] the court found that claimant's past education, background, work history and present age were factors which "equip him only for work which involves a considerable amount of physical exertion, that he is dependent for his living upon the ability of his body to function at or near capacity." When he is not able to so function he is disabled under the Act.

In *Lease* v. *Flemming*,[15] the claimant was 62 years old; he had three years only of formal schooling; and he had worked as a manual laborer and later as a steeple jack. He had lost the sight of one eye and the other was badly impaired; his right hand was severely injured and he suffered from respiratory difficulties; and he was 5′11″ and weighed 252 lbs. The judge wrote in what amounted to a hearing *de novo*, that "* * * personal examination convinces *me* that such work is not reasonably possible for this claimant * * *," and cited in support of his conclusions the reasoning of Mr. Justice Black (who reached a similar result under another act) in *Berg* v. *U.S.*, 312 U.S. 450 in reversing a case tried by a judge and jury.

In two other severe hardship cases, the courts reversed the Secretary on applications by claimants with limited capabilities. In one (*Crooks* v. *Folsom*, 156 F. Supp. 631, N.Y. 1957) claimant had a serious silicosis after working in limestone quarries, he was 59 years of age, had only four years of formal schooling and no physical capacity for sustained activity. In another case (*Parfenuk* v. *Flemming*, 183 F. Supp. 532 (Mass. 1960)) claimant was 64 years old, born in Russia with less than 5 years of schooling there and no evidence of any real education in the United States. He had been a wood chopper, coal miner, shoveler and later upholsterer of furniture, who had lost the unimpeded use of his right hand and could not do any of the work required by his earlier jobs. Applying the *Underwood* case test, part 4, how could he be not disabled? Yet, under the standards of the Social Security Act these reversals are questionable. But they appear to achieve a just result. so far as the "Court's Standards" are relevant.

In *Sobel* v. *Flemming*,[16] claimant was 53 years old, had gone through two years of high school. He had been an industrial plant painter and had done some supervisory work in that activity. He had been injured in an automobile accident, lost the lower part of his leg and suffered from pain from the severed nerve endings. He had done some work at home but it took him six days to do a paint job he could do in an hour before the accident. He had no other trades and was not easily trainable. The court, feeling the Social Security Act to be remedial and therefore to be liberally construed, found him disabled. This case is perhaps more a borderline case then the others. It is, nevertheless a law/fact/policy decision within the court's competency.

A similar result was reached in *Holt* v. *Flemming*.[17] The claimant was 56 years old, had received 7 years of schooling. With respect to a back injury in 1949, four doctors found a progressive, severe and generalized arthritic condition, and concluded that he was "totally disabled." Two doctors made an examination after the hearing; they were not familiar with the plaintiff's record. Their report was added to record after the hearing but was not conclusive. After an *independent evaluation* of the evidence, the court said the man was clearly disabled, for "*there is no substantial evidence to the contrary.*"

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[14] 298 F. 2d 850, 852 (1962).

[15] 178 F. Supp. 169 (1959).

[16] 179 F. Supp. 891 (1959).

[17] 198 F. Supp. 622 (1959).

Finally, in *Butler* v. *Flemming*,[18] the opinion concludes in a similar vein, but with a devastating analysis of the law:

> When the claimant could no longer shuffle dominoes (he had a small domino parlor; after he was unable to hold his much more active former job) he was not required by the use of a catalogue of the nation's industrial occupations to go down the list and wholly negative his capacity for each of them, or their availability, to him as an actual opportunity for employment.

As the cases disclose, while attitudes favorable to the substantial evidence rule have been taken by courts, they have often at the same time reversed the Secretary's finding in an elaborate record as in the *Underwood* case. The mere analytical separation of formulae used in the test has not yet seemed to provide a useful tool for the courts in these very subjective policy determinations.

While many cases of the borderline variety have troubled the courts, in cases where the equities are weak, e.g. simple obesity cases,[19] remission of diabetes,[20] tuberculosis,[21] or pernicious anemic condition,[22] the "substantial evidence" guides are uncomplicated by the subjective or relative disability problems and are more likely to be useful to, and followed by, the courts on the subjective or relative disability problems and are more likely to be useful to, and followed by, the courts on the basis of past experience. In a borderline case where a man has semi-skilled occupation requiring education of a high school level, has worked many years, is in late 50's and injured seriously, the problems of adjustment to a menial task to keep alive until Social Security at age 65 may be so extremely difficult as to be "disability." These are more difficult cases for courts to avoid *de novo* and "clearly erroneous" tests when they review the "ultimate fact determination." Here again the Courts of Appeals holdings on relative disability cannot be separated from the test of the "substantial evidence formula." An extreme case of this type is *Boyd* v. *Folsom*,[23] where the deceased husband died during sexual relations and HEW held he and his wife were not living as man and wife at the time. Biggs, Chief Judge, said at p. 781, in reversing HEW:

> Since ultimate facts must be reached by a proviso of legal reasoning based upon the legal significance to be afforded primary evidentiary facts, this aspect of administrative fact finding has its law-making aspect and is therefore reviewable."

Citing *Goldwan* v. *Folsom*, 246 F. 2d 776, 779 (3 Cir. 1957); *Baumgartern* v. *U.S.*, 322 U.S. 665 (1953); *Lehmann* v. *Acheson*, 206 F. 2d 592 (3 Cir. 1954; *Galena Oaks Corp.* v. *Scofield*, 218 F. 2d 217 (5 Cir. 1954). That the statute had technical tests calling for a refusal of aid was overlooked or at least overcome by Judge Biggs in a review *de novo*.

IV. THE ROLE OF AGENCY "EXPERTISE"

The federal courts, where all of the reviews of the Secretary's findings under the Social Security Act occur, have long been familiar with issues of physical disability following an injury in an accident or resulting from some prior event that leads to permanent illness. The judges believe they are peculiarly well equipped by experience and judicial precedent to pass on the issues of fact as well as those of law involved in contested disability cases. In short, the courts presume a personal "expertise" in these familiar areas which have not traditionally been consigned solely to agency determination. In recognition of this tendency, Professor K. C. Davis, the author of the standard and monumental text on Administrative Law, has set forth in Section 30.09 a controlling guide which suggests that courts should take up detailed review of those issues which are familiar to them and subject to their experience and expert judgment, but leave to the administrative regulatory officials resolution of the newer administrative issues which are not to be found in court opinions, because they are derived from the more general administrative standards which require policy-made guides from the administrative agency and its regulations. For this reason, courts should hesitate to inquire deeply into an unfamiliar administrative technical or economic hearing to review *de novo* or evaluate the substantial evidence in the record.

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[18] 288 F. 2d 591, 595 (1961).

[19] *Wray* v. *Flemming*, 181 F. Supp. 783 (Ark. 1960) (obesity-373 lb. man).

[20] *Stitely* v. *Flemming*, 178 F. Supp. 357 (Md. 1959).

[21] *Pagelow* v. *Flemming*, 189 F. Supp. 671 (N.J. 1960).

[22] *Craig* v. *Ribicoff*, 912 F. Supp. 479 (N.C. 1961); *Heath* v. *Ribicoff* (D.C.S.C. 1962), (pernicious anemia).

[23] 257 F. 2d 778 (1958).

The question of the true aspects of the court's expertise is presented in a more challenging light in the recent case of *Littleton* v. *Ribicoff* (E. D. Ky. 1962) where the court after tabulating several complicated medical reports said:

> The most that can be said of the foregoing is that it represents a divergence of opinions among the various physicians who have examined the plaintiff. It is not for the court to set this controversy at rest. This court is limited in its jurisdiction to review to an examination of the record to determine that there is substantial evidence to support the decision of the administrative authorities (42 U.S.C.A. 405(g)). Where the evidence is conflicting and will support a number of diverse inferences, the choice of theories is to be made in the Social Security Administration, not in the courts.

Again, after noting another series of conflicting medical reports, the court said:

> The choice among conflicting inferences is to be made by the Social Security Administration.
>
> The evidence does not by any means compel a different conclusion from that of the examiner. If the court were trying the case *de novo* it would be very difficult to decide whether plaintiff is able to work or not. As it is, however, the court is presented with a completed decision and can only determine that there is some evidence and some logic underlying it (42 U. S. C. A. 405(g)). *The inaccessibility to lay perception and sheer multiplicity of factors which determine disability make this field especially appropriate to judicial restraint* * * *. The Social Security Administration on the other hand, by the disposition of countless disability claims made under this Act acquires an expertness that should not lightly be challenged. Federal courts are under an obligation to be mindful of the superior facilities of the day by day administrator. Mr. Justice Frankfurter concurring in *Trust of Bingham* v. *Commissioner*, 325 U.S. 365, 377 (1945)." [Italics added.]

While this argument has a persuasive ring, the district courts and courts appeals have not by any means, as the cases show below, been willing to grant that the expertise of the Administration by its countless cases is greater than their expertise from cases over many years of countless cases.

There has, however, been a qualified acceptance of the argument in favor of agency expertise. In *Rubin* v. *Flemming*,[24] for instance, the Court said:

> While the court is aware that the review of administrative decisions should be approached with some deference, based not only on the expertise of the agency, but also on an awareness that Congress placed the administration of a complex body of law in that agency, it is likewise clear that the court may not abdicate its judicial function.

And in *Stoliaroff* v. *Ribicoff*,[25] Judge Foley offered the same general qualification, stating:

> The fundamental and elemental concept must be recognized that the legislative words conferring conclusiveness upon facts found by the administrative agency, if supported by substantial evidence, is to be carefully adhered to by the specialized agencies and should not be frustrated or intruded upon to any degree by personal judicial viewpoint if substantial evidentiary support is found in an examination of the whole record. The finality accorded to found facts extends to inferences to be drawn from conflicting evidence if so sup-

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[24] 172 F. Supp. 590, 592.

[25] 198 F. Supp. 587, 588.

> ported * * *. However, it is clear from the grant of power under Sec. 205(g) of the Act to modify or reverse the Secretary with or without remanding the cause for rehearing or for good cause shown to remand for additional evidence that Congress did not contemplate blind, mechanical stamp of approval by the Court when search of the whole record does not satisfy the judicial conscience that the substantial evidence standard has been met.

On the record, the Social Security Administration appears, at least in the field of disability evaluations with which we are here concerned, to merit greater deference to its judgment than the courts have been willing to accord. We do not suggest that it would be fair or accurate to postulate that "agency expertise" is unique to the DIB program alone among the family of administrative disability decisionmakers. It is probably more correct to say that the circumstances in which the program was originally established, the climate of operations, and the administrative attitudes which prevail in its policy formulation, staffing, organization and procedures appear to be significantly more favorable for expertise to fluourish than one is likely to find in other programs. This advantage is to some extent historical and to some extent the product of planning on the foundation of the experience of the other programs.

V. THE "CLEARLY ERRONEOUS" MISCONCEPTION

"Clearly erroneous" is a judicial concept which is seldom mentioned and infrequently defined. Rule 52(a) of the Federal Rules of Civil Procedure, in defining the scope of appellate review of factual issues from a trial court sitting without a jury, provides that:

> Findings of fact shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge the credibility of witnesses.

The leading Supreme Court decision on this doctrine is found in *U.S.* v. *U.S. Gypsum Co.*:[26]

> Since judicial review of findings of trial courts does not have the statutory or constitutional limitations on judicial review of findings by administrative agencies or by a jury, this Court may reverse findings of fact by a trial court where "clearly erroneous." * * * A finding is "clearly erroneous" when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed.

Theoretically, then, the "clearly erroneous" test is one that is broader than the "substantial evidence" test. On review, a court of appeals could conceivably have a definite and firm conviction that a mistake had been made even though there was evidence in the record to support both conflicting theories of the case. This thesis was enunciated in *Cantrell* v. *Ribicoff*[27] in these words:

> The scope of judicial review granted a District Court by section 405(g) is not as broad as the scope of review granted a Court of Appeals under Rule 52(a) of the Federal Rules of Civil Procedure. The Court of Appeals has power to set aside a District Court's finding of fact determined to be "clearly erroneous." *A "clearly erroneous" finding of fact conceivably could be supported by "substantial evidence."* The Supreme Court has pointed out that "a finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed," (citing *U.S.* v. *U.S. Gypsum*). [Emphasis supplied.]

However, the confusion is compounded by the holding by the Supreme Court in *U.S.* v. *Yellow Cab Co.*[28] that "* * * a choice between two permissible views is not 'clearly erroneous'."

What is germane here is that, notwithstanding the *U.S. Gypsum* decision distinguishing between judicial review of trial *courts* and statutory limitations on judicial review of *agency* findings, there is evidence of confusion in the application of the two tests. For instance, in *N.L.R.B.* v. *Radio Officers' Union,*[29] the Court there said:

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[26] 333 U.S. 364. 395.

[27] 206 F. Supp. 436, 438.

[28] 338 U.S. 338, 342.

> The record contains nothing which would justify holding the findings to be clearly erroneous; hence they are supported, by "substantial evidence" as the statute requires.

In a seminar conducted at the University of Michigan, a survey of circuit court cases using the "substantial evidence" rule or the "clearly erroneous" rule, indicated that there was considerable confusion in application of the two.[30]

Part of the confusion is deliberately generated. As observed, if a federal district court, or court of appeals, finds itself in a familiar area of disability resulting from an injury or accident, its first reaction has generally been to treat this subject as a matter especially suited to the judicial method or expertise, and give the facts an independent evaluation comparable to a trial "de novo." When thinking in these judicial terms it is also very congenial to such judges to think in terms of a review under the "clearly erroneous" doctrine. Moreover, a certain line of cases for review of administrative regulatory agencies combines these two concepts very easily under the concept of the "ultimate fact issue," which is an application by a reviewing court of the legal standard of the evidential facts to make a final legal determination.

The distinction between "evidential" facts and "ultimate facts" frequently defies classification. Taken together with the "clearly erroneous" misconception, a strong argument can be made for the elimination of the "substantial evidence" rule. One authority [31] (and the same view was shared by the Hoover Task Force) offers the following reasons in favor of elimination of the rule:

1. Many judges confuse the two.
2. "Substantial evidence" is not an objective formula or one easy of precise and uniform application.
3. Too many lawyers use "substantial evidence" to uphold the correctness of findings when the real question is the reasonableness of the findings.
4. "Substantial evidence" rule is needed mainly for lengthy records but not short, concise ones.

Mr. Cooper and the Hoover Task Force are both in favor of broader review and argue that this can best be accomplished by adopting one test—"clear error."

Our view, however, would be to the contrary. Confusion in application of the "substantial evidence" rule is a function of the lack of appropriate judicial restraint. In reviewing determinations of the Secretary under the Act, the courts should be guided by the philosophy of Judge Foley of New York articulated in *Stoliaroff* v. *Ribicoff*: [32]

> Disability to any extent arising from illness and distress creates sympathy and emotion in the heart of every citizen whether he be layman, referee or judge. However, balanced judgment must be made in accordance with legal principles no matter the harshness of result because that is the pride of our system of law. Comfort comes only from the knowledge that this massive humane program is under continuous executive and legislative study with the assistance of distinguished and dedicated citizens and committees expert in the social assistance and security field. (Citing cases.) This noble legislation now taken for granted was initiated and has been extended and clarified by executive and legislative wisdom when necessary. In my judgment, the judicial branch should use its powers sparingly in this field to correct only manifest injustice or obvious erroneous administrative procedure or decision.

As the Fourth Circuit said in *Snyder* v. *Ribicoff:* [33]

> When there has been an administrative determination, however, whether in favor of the claimant or not, there is no right to have the

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[29] 196 F. 2d 960, 962.

[30] "Administrative Law: The 'Substantial Evidence' Rule," Frank E. Cooper, ABAJ, 44: 945, O. '58.

[31] Ibid.

[32] 198 F. Supp. 587.

[33] 307 F. 2d 518, 520.

District Court review the factual issue. The District Court is required to accept the administrative findings if supported by substantial evidence. That there may have been substantial evidence to support inconsistent findings has no bearing upon the District Court's inquiry. He must view the record as a whole, but not for the purpose of making independent findings. His task ends when he determines whether or not there is substantial evidence to support the administrative findings.

VI. THE EXAMINER'S FUNCTION

No matter how persuasive the argument in favor of judicial restraint, the literal application of the substantial evidence rule by the courts will continue to be ignored unless there is a concomitant redefinition of the role of the Hearing Examiner.

The Act provides that:[34]

> Any individual dissatisfied with any determination under subsection (a), (c), or (g) of this section shall be entitled to a *hearing* thereon by the Secretary * * *. [Emphasis supplied.]

A "hearing" within the meaning of the statute is not a "review," and the Hearing Examiner is in no sense a "reviewing" authority. To say that it is not the function of the District Court to resolve factual conflicts, including contrary opinions expressed by doctors, presuppose that the Examiner must perform the function of drawing the critical inferences of facts and law. He should, in short, conduct a "hearing" and not undertake simply to "review" the prior adverse determinations of the State Agency. As the court said in *Hayes* v. *Celebrezze:*[35]

> Important as is the routine administrative determination concerning the merits of claims, the scheme of the statute and the implementing regulations call for an initial determination of all of the relevant questions by the Hearing Examiner entirely independent of the conclusions previously reached administratively.
>
> * * * * * * *
>
> * * * in this function he is in no sense reviewing the prior decision of the administrative agencies or the sufficiency of the record to support their findings.

In addition to understanding his role as the trier of facts, the Examiner must approach the discharge of his function with complete objectivity. A clear statement of this principle is found in *Snyder* v. *Ribicoff*[36] in which the Fourth Circuit observed:

> The Act does not require administrative resolution of evidentiary conflicts in favor of the contentions of the applicant. The Hearing Examiner, subject to review by the Appeals Board [sic], is to find the facts. He should approach that important function with a sense of fairness. He should seek the truth without predisposition to find for or against the claimant. He should consider the evidence objectively and make his findings dispassionately.

Finally, the Examiner should assume the responsibility of producing a comprehensive record. Poor development of a case is an invitation to a *de novo* proceeding rather than a review. Judge Brown made the following observation in *Hayes* v. *Celebrezze:*[37]

> Of course one thing of critical importance is the nature of the proceeding. That makes it essential to bear in mind what Judge Friendly emphasized in *Kerner* v. *Flemming*, 2 Cir., 1960, 283 F. 2d 916, 921–922, that these so-called records lack much of the formal comprehensive attributes of a typical administrative record.

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[34] 42 U.S.C. sec. 421(d).

[35] —F.2d—; CCA-5, No. 19630, Jan. 3, 1963.

[36] 307 F. 2d 518, 520 (1962).

[37] Supra at footnote 36.

And with reference to the specific "record" before him in *Hayes*, Judge Brown went on to state:

> The result is that by the peculiar circumstances of this record, the Hearing Examiner either did not fulfill his role, made fact findings which are not adequately supported, or failed to resolve crucial issues.
>
> When the fact findings carry with them such operation finality as they do under this statutory plan, we must be certain that in arriving both at the ultimate decision and the essential subsidiary facts, the Examiner has evaluated all of the evidence under proper standards. Where these turn on credibility choices concerning things as elusive as the truthfulness of subjective symptoms and complaints, the Examiner's report should afford some indication of the choices made and the basis for them. (The decision was reversed and the case remanded for further development.)

VII. RESTATEMENT OF THE RULE

Given a scheme of review which presents comprehensive records developed in an objective "hearing," the courts will be prone to grant appropriate deference to agency "expertise" and to adopt as a formula of review the following classic statement from Scott v. Ribicoff:[38]

> Keeping in mind that substantial evidence requires only such relevant evidence as a reasonable mind might accept as adequate to support a conclusion, let us consider what evidence was available to the hearing examiner upon which he based his conclusions.

J. FORESTER DAVISON,
Professor Law.
GEORGE J. GOLDSBOROUGH, JR.,
Professorial Lecturer in Law.

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[38] N.D. La., July 20, 1962 (unreported).

I. VOCATIONAL AND MEDICAL EXPERTS

Those who have decisionmaking authority in the disability adjudication process need assistance from specialists in the assessment of the vocational and medical factors. The use of such specialists differs markedly at each decisionmaking level—State Disability Determination Unit at the initial decision and reconsideration levels; Bureau of Disability Insurance at the Bureau review level; Administrative Law Judge and Appeals Council at the Bureau of Hearings and Appeals level. This section will attempt to bring out these differences and focus attention on some of the issues that have been raised about their use. Unfortunately the staff has not had the time to make the onsite visits and other evaluation studies which would be necessary for a definitive treatment of these subjects. The staff believes, however, that such evaluation should be included as a part of a proposed study of the hearings and appeals process which is now being considered by the Department of Health, Education, and Welfare.

VOCATIONAL EXPERTS AT THE HEARING LEVEL

Some consideration has been given to vocational factors in the evaluation of disability since the beginning of the Disability Insurance program. In the early days of the program, these factors were little emphasized and, as it has been pointed out in other sections, lack of amplification in the regulations led to judicial intervention in the formulation of the basic policy of the Social Security Administration's program for vocational assessment. The effect of the *Kerner* decision (*Kerner* v. *Flemming* (1960) 282 F. 2d 916) in the early 1960's was immediately felt by the Office of Hearings and Appeals (predecessor of the present Bureau of Hearings and Appeals) which had to deal with the remanded court cases where the courts had directed that answers be supplied to the questions posed by the *Kerner* decision:

> What are the types of work the claimant can do? What employment opportunities exist for a man who can do only what the claimant can do?

In 1962 the Office of Hearings and Appeals established a nationwide program for expert vocational testimony at the hearing level. By 1965 the number of vocational experts under contract for hearings had increased to 650 and has remained fairly constant at that level since then. Their usage in live testimony, however, has increased from slightly under 5,000 in 1965 to over 13,000 in fiscal 1973. Personnel of the American Personnel and Guidance Association and the American Psychological Association were consulted in establishing the criteria for the selection of these experts and these professional associations have played a major role in developing the program up to the present time. The criteria for selection of vocational experts includes such abilities as skill in vocational counseling and placement of the handicapped; ability to use occupational materials and classifications such as the Dictionary of Occupational Titles; the facility to use and interpret psychological tests relating to occupation placement; and the possession of knowledge of and experience with labor market trends, local labor market conditions, and worksettings. Included in the group of vocational experts have been professors of psychology, education, and rehabilitation counseling, directors of private counseling and employment agencies, assistant dean of students, director of institutional research and counseling in a college, consultant in counseling in a public school system, etc.

The use of the vocational expert in a hearing situation where he is the last witness called by the Administrative Law Judge (ALJ), is demonstrated in the following excerpt from the manual prepared by the Bureau of Hearings and Appeals. It gives what is considered the proper method of questioning of the vocational expert by the ALJ:

Q. Dr. Jones (the Vocational Expert), we have a picture of what Mr. Smith did in the past from the documentary evidence of record. Will you kindly summarize his background, especially his work experience and all other factors which you take into consideration in evaluating vocational capacity of an individual, especially Mr. Smith's.

A. Mr. Smith's vocational history has been of short-term employment with no specific vocational training in any one field. His education is limited to ninth grade, according to the testimony I have heard and the documents that I have reviewed. I find no evidence of specific vocational training or skilled job experience. The positions that Mr. Smith has held can be broken down into various unskilled jobs. According to the record, I find that the work history can be summarized in the following way. He has held positions as cook helper, kitchen helper, painter's helper, porter, stock boy, and houseman. Mr. Smith's entire work history, even though it has been in different positions, has a certain similarity. The work performed has to do with activities involving little or no judgment and little adherence to rigid standards. Most of the work requirements of all of the jobs mentioned require an occupationally significant combination of physical stamina, inclination to routine work, repetitive activity, some degree of dexterity with fingers and hands, eye-hand coordination, some degree of of form perception, and the ability to follow instructions. The training required on most of his previous experience is elemental. In other words, a short-term period of training would be necessary, which might be limited to one day on the job telling him what to do. Physical demands of his previous occupations run the gamut from light, medium, heavy, to very heavy. I believe this gives you some idea of his past experience.

Q. The jobs that you mentioned were jobs that you found the claimant had done some time in the past according to the record, is that right?

A. Yes, sir.

Q. Now, Dr. Jones, what is your understanding of sedentary work?

A. (Answer given probably as in Dictionary of Occupational Titles.)

Q. What is your understanding of light work?

A. (Answer given probably as in Dictionary of Occupational Titles.)

Q. What is your understanding of moderate work?

A. (Answer given probably as in Dictionary of Occupational Titles.)

Q. Under the assumption that I will find from the medical evidence in this case that there is no physical impediment to Mr. Smith's undertaking and performing sedentary (light or moderate) work activity, as same was described by you, do you know of any jobs which exist in this region which you feel Mr. Smith is vocationally qualified to perform based on his age, education, training, and background?

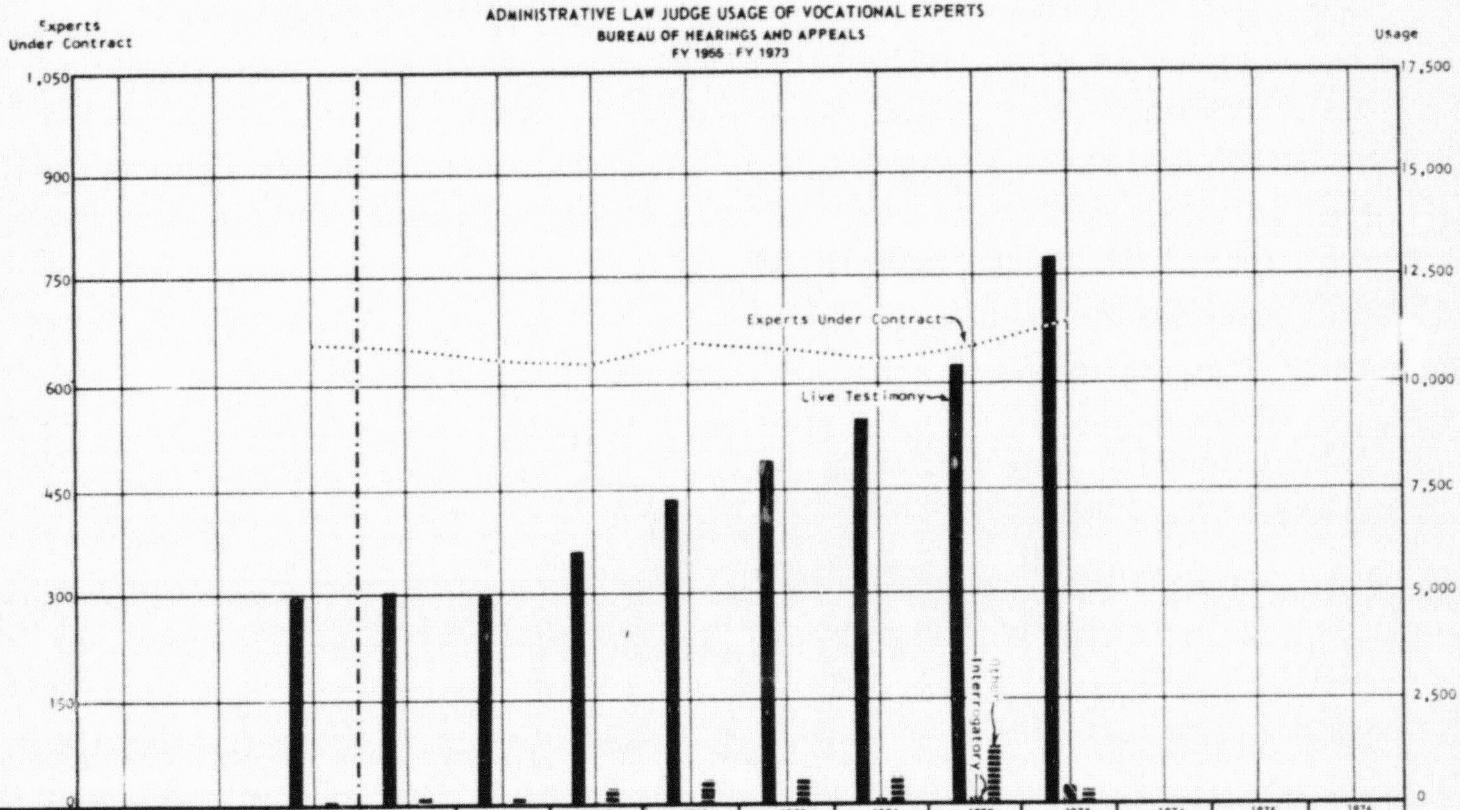
A. (Vocational expert responds.)

In the above example, the hearing examiner, if the evidence so indicates, can follow through for further amplification with specific questions as to the physical requirements, such as the necessity for bending, lifting, turning, stooping, etc.; the tools and equipment used; the working conditions; and the occupationally significant characteristics associated with the jobs named by the vocational expert. This method of examination permits the vocational witness to give full explanation to the appropriateness of the job without trying to include all such information in the preliminary question. This has been found to be a sound technique for questioning vocational witnesses.

ADMINISTRATIVE LAW JUDGE USAGE OF VOCATIONAL EXPERTS

BUREAU OF HEARINGS AND APPEALS

FY 1955 - FY 1973



CATEGORY	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
EXPERTS	--	--	656	650	637	625	657	647	635	652	683			
LIVE T'Y	--	--	4,867	5,045	4,987	6,034	7,252	8,142	9,215	10,337	13,074			
INTERROG'Y	--	--	--	--	--	--	--	--	167(b)	158	399			
OTHER (a)	--	--	219	339	274	433	555	580	631	1,299	330			
TOT USAGE	--	--	5,086	5,384	5,261	6,467	7,807	8,722	10,013	11,794	13,803			

SOURCE: BHA:A-4

(a) Claimant did not appear at scheduled hearing, hearing was postponed for good cause, etc.

(b) Contract provided for interrogatories for first time in FY 1971.

Acceptance of the Vocational Expert Program

S. Norman Feingold, in his book "The Vocational Expert in the Social Security Disability Program" (1969), has stated that even

> * * * in those decisions adverse to the Secretary, the courts did not criticize the vocational expert technique, but merely the content of the testimony given in the particular cases. In fact, every Court of Appeals which has spoken on the question has accepted the use of vocational experts as a means of sustaining the Secretary's burden of proof. Several of these courts have gone so far as to find that live vocational testimony is the best possible method of vocational evidentiary input (p. 174).

Recent reports of the Department of Health, Education, and Welfare state that vocational expert testimony continues to be contained in numerous court affirmances and reflects the importance of such testimony in judicial thinking. The Bureau of Hearings and Appeals has declared:

> In terms of costs, it is impossible to state in exact dollars and cents how many judicial decisions favorable to the Secretary might have been unfavorable if vocational expert testimony had not been obtained. It can safely be stated that in the six District Courts with the highest volume of cases, literally millions of dollars have been saved because of vocational testimony; these courts are: Puerto Rico; South Carolina; Eastern District, Kentucky; Southern District, West Virginia; Southern District, Ohio; Northern District, Alabama; all of which require the Secretary to produce vocational testimony if the record shows the claimant cannot do his usual work. During calendar 1972 these six courts affirmed the Secretary in 232 disability cases. Without undertaking time-consuming research for case-by-case discussion, it is conservatively estimated that in 125 of those, the result would have been different except for vocational expert testimony. The same can be said of approximately 25 of the 36 cases affirmed by the Pennsylvania courts, and the 10 of the 20 affirmances by the Western District, Louisiana court. Therefore we have in excess of 150 cases where vocational expert testimony was instrumental in having the Department's decision upheld.

A recent example of judicial insistence on live vocational testimony was the *Garrett* case (*Garrett* v. *Richardson* (1972) 471 F. 2d. 598) in the Eighth Circuit. The court stated:

> No expert in vocational training was ever called to testify in this case, nor was any report submitted, nor was any testimony elicited concerning what type of "light or moderate work" appellant could perform with *his* education, *his* age and *his* work experience that would be commensurate with substantial gainful activity. In such circumstances, it cannot be said that a finding of no disability is supported by substantial evidence (p. 603).

In a later case in the Eighth Circuit (*Johnson* v. *Richardson* (1973) 486 F. 2d. 1023) the Court stated:

> Our statement in *Garrett* does not mean in every Social Security disability hearing the administrative judge must call as witness a vocational counselor. Where, however, the essential issue relates to the capacity of the claimant to perform a specific job and *there is no other evidence directly on that issue*, in order for the record to be fully and fairly developed, a vocational expert should be called (p. 1025).

Some commentators have reservations about the vocational expert program at the hearing level. Robert Dixon writes (on the basis of an admittedly limited number of personal observations of live hearings):

> Because the statutory definition of disability is so strict and because there are so many nonlaborious low-level jobs in an industrial economy that even severely handicapped persons can perform, it would be expected that vocational consultant testimony before hearing examiners would support a denial. Studies by the SSA's own research

> organization bear this out. Indeed, the statute would seem to support adverse presumption in all close cases. The courts, however, frowned on early attempts to prove abstract capacity for gainful employment by merely citing the Dictionary of Occupational Titles, or other Department of Labor documentation, and required live testimony. At the same time, the disability program is not an employment program, and actual capacity to be hired for a given job is not a permissible consideration.
>
> This combination of circumstances forces the vocational consultant, as an expert witness, into an almost demeaning position and confuses the claimant. The consultant talks only in generalities about the world of work in the particular region, and his live testimony is less informative, and more expensive, than would be a report from the U.S. Employment Service. The claimant naturally wants to know where all these jobs that he supposedly has the capacity to perform are. Some revision is needed, by statute or by regulation, concerning the manner of proof of the existence in the national economy of jobs within the apparent residual capacity of the claimant (p. 150).

There has been an increasing use of contracts with the United States Employment Service to provide surveys of jobs of a light and sedentary nature available in various geographic areas for individuals with limited skills and education. These surveys have been expanded to include thirteen States and have become an increasingly more significant part of the Bureau of Hearings and Appeals budget, rising from $25,000 in fiscal 1971 to about $400,000 in fiscal 1974.[1]

STATE AGENCY LEVEL

The question has been raised as to why the assessment of the vocational factors does not occur in more depth earlier in the adjudication process. Certainly, the degree of emphasis that is placed on the assessment of the vocational factors at the hearings level does not appear to exist in the determinations of disability by many State agencies—at least as far as it is accomplished by personnel with special expertise in this area. There are logical reasons for this. They are primarily (1) the high-volume operation at the State agency level where most of the cases are determined on the basis of medical factors alone, and (2) the higher proportion of borderline cases that exist at the hearings level. However, the Social Security Administration has informed the staff that about 20 percent of current allowances are based on the vocational factors. The information on the number of vocational specialists State-by-State (which appears in Part III, page 233) shows a broad divergence in staffing in this area by the State agencies. Moreover, this information shows that there were only 98 vocational specialists in the State agencies throughout the entire United States—and 18 in Texas alone—who reported to BDI in January 1974. This would indicate that in most States an expert is not available to consult with the disability examiner in his day-to-day caseload. The same uneveness is reflected in the use of the "comprehensive vocational assessment" (described in Part III, pages 235–236) which is a referral to an independent consultant or facility for examination and assessment of the more difficult borderline cases. Although this latter program was launched with considerable fanfare, only about 14,000 such assessments have been made in a 10-year period. Moreover, of these assessments, 4,000 were carried out in two States—Ohio and Missouri. On the other hand, the high-volume States of California and New York show 460 and 231 assessments, respectively, for the overall period. Federal District Judge Frank Kaufman, who is based in Maryland, had this to say on the disability determination process generally, and, more particularly, on the lack of use of assessment facilities:

> One separate line of comment before I close. And that goes to what seems to be the piecemeal, largely uncoordinated use of medical and job-availability experts in the investigation and in the grant or denial of disability claims. There is little coordination among the

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[1] At the present time it does not appear that the State agencies are using these BHA studies in their vocational assessments.

> doctors. There is seemingly less between them and the vocational experts. So often, the record reaching a district court reveals a minimally educated low I.Q. claimant allegedly suffering from manifold physical and emotional impairments. The claimant is referred successively to private practitioners specializing, let us say, in orthopedics, cardiology and psychiatry. Each doctor gives his separate written assessment. Those written assessments are considered by medical and nonmedical administrative personnel and are related to the job market and vocational opportunities. And, if the claim is denied and an appeal is taken, all of this can culminate in a hearing before an administrative judge with the claimant appearing without counsel and with a vocational expert testifying to the availability of sedentary work as a movie theatre ticket seller or taker for the 57-year-old shoe saleslady who no longer can sell shoes as she has for 30 years before she broke her ankle because of her ankle suffers and because she also suffers from angina and has a history as a psychiatric in-patient. No one doctor has worked up her case. No one person has talked to the doctors who examined the lady. True, administratively, one or more persons have attempted coordination and overall consideration. But the application of a skilled physical medicine approach has in no way been utilized. In Baltimore, we have at least three, perhaps four, hospitals, federal, state and private, admirably staffed and equipped to work with knowledgeable laymen in diagnosing, treating, and guiding into jobs they can perform, partially disabled persons. Yet those facilities are almost unused by the Social Security Administration. ("District Court Review of Department of Health, Education and Welfare Decisions," Administrative Law Review, Winter, 1974, p. 117.)

It is interesting to note that Maryland had only one vocational specialist on duty in its disability determination unit in January 1974 and that it had undertaken only 73 comprehensive vocational assessments during the period 1964–73. The reasons for the differences in background and qualifications of the vocational expert at the hearing level and the vocational specialist at the State agency are not clear. The following excerpt from a basic policy letter from the Bureau of Disability Insurance to the State agencies in 1967 emphasizes the differences between the two types of personnel but offers little encouragement and no requirement for the use of Bureau of Hearings and Appeals vocational experts by the State agencies:

> The Bureau of Hearings and Appeals has had a great deal of experience in cases at the appellate level with the use of vocational consultants as expert witnesses testifying as to the jobs and fields of work in which claimants can engage. The nation-wide panel of consultants available to hearing examiners includes primarily psychologists and other specialists in education, vocational counseling and rehabilitation, who are members of the American Psychological Association and the American Personnel and Guidance Association. While we have no objection to State agencies using the services of members of the Bureau of Hearings and Appeals panel who may be available to them, we are not providing a similar nationwide listing because we expect that each agency is in the best position to develop its own sources of professional services in its area. Any State agency wishing more information about the consultants listed by the Bureau of Hearings and Appeals should request it through the Regional Office.

The vocational specialist at the State agency level is most commonly a senior disability examiner[2] who has primarily had on-the-job training in vocational assessment and, in some cases, a training course in the central office in Baltimore. The staff's review of the reports of some of these specialists indicate that many of them have substantial responsibilities in the training of new examiners.

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[2] The vocational specialist is usually in a higher pay classification than the disability examiner.

Responsibility for development of the work history in the initial interview with the claimants has recently been removed from the District Office and is being carried out, on a when-needed basis, by the State agency. Information on this new procedure, which was not pilot tested,[3] is not yet available. We do not know, for instance, whether State agencies are following the instructions of BDI which call for letter and telephone development or, as a last resort, using the District Office in getting enough documentation on the vocational factors for adequate adjudications.[4] A study of this is reportedly in progress. Certainly the question should be explored as to whether this latest development is having the effect of placing further reliance on the appeals process for the full development of the vocational factors.

The use of studies on job availability raises some interesting legal points. The Bureau of Hearings and Appeal was asked by staff to describe the practice of Administrative Law Judges in taking "administrative notice" of the existence of light and sedentary jobs and the Social Security Rulings or Appeals Council decisions which were controlling as to policy in this area. In a memorandum in response to this request, the Bureau answered:

> Under Section 7(d) of the Administrative Procedure Act an agency may take official notice of facts at any stage in a proceeding providing that such facts be specified and any interested party given the opportunity to show to the contrary.
>
> Although there are Appeals Council decisions which discuss this subject, such decisions are not circulated to the ALJ's as was the practice a number of years ago. Accordingly, unless the decision of the Appeals Council is the subject of a Social Security Ruling, it does not provide any guidance to the ALJ's.
>
> There is a Social Security Ruling, SSR 64–65c, CB 1964, p. 135, based on a court case which is pertinent to this subject (*McDaniel* v. *Celebrezze*, 331 F.2d 426 (4th Cir 1964)). The syllabus of the ruling reads as follows:
>
> "Where Secretary, in addition to testimony and documentary evidence presented at hearing, considered pertinent recognized publications in this case certain medical texts and industrial and governmental studies of the requirements and availability of various jobs; and where plaintiff had been given an opportunity to challenge and contradict such materials: *held*, the Secretary's taking official notice of such publications in reaching a decision was proper."
>
> The Court in its decision stated that "Sections 205 (a) and (b) of the Social Security Act implicitly authorize consideration of this type of evidence. The procedure followed by the Appeals Council conforms with § 7(d) of the Administrative Procedure Act." The court then concluded "that taking official notice of recognized publications is not, in itself, grounds for reversing the decision of the Secretary when the requirements of § 7(d) of the Administrative Procedure Act have been met." The court emphasized that reviewing courts must carefully evaluate this type of evidence in determining whether there is substantial evidence in the record taken as a whole to support the decision of the Secretary.
>
> *Taking administrative notice of the incidence of jobs of the economy is clearly permissible under the Administrative Procedure Act and the aforementioned Social Security Ruling. However, the Secretary must first respond to the issue of what type of work this claimant can do. This requires the use of live testimony by a vocational expert* (emphasis added).

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[3] The decision was made on the basis of District Office complaints that the detailed work history questions were not being used in enough adjudications to warrant their inclusion in the initial interview. The SSA states that a check of a sample of cases seemed to bear out this complaint. Somewhat ironically from a workload standpoint, the previous State agency function of determining whether work activity constitutes substantial gainful activity was transferred to the District Office at about the same time.

[4] Under current instructions the Administrative Law Judges are also supposed to get further development of the vocation evidence in the file through the District Offices. Whether this too is to be modified is not clear.

The Bureau of Hearings and Appeals memorandum goes on to state that once the vocational expert is present at the hearing "to respond to the issue of what type of work the claimant can do, he can and is expected to also respond to the issue concerning the incidence of those jobs in the economy." The memorandum then argues that the use of live testimony is the preferred approach in that the ALJ does not have to become an expert in job availability; that the "administrative notice" approach is not tailored to the individual claimant; that the testimony of the vocational expert may help the claimant in his subsequent search for employment; that the Courts and Justice Department are accustomed to vocational expert testimony, and that it is fairer to the claimant in allowing a live cross-examination.

Although the staff is not necessarily unconvinced by this argumentation, there are elements of it which are worthy of examination.

First, the validity of the underlying premise is not clear, i.e., that live testimony is necessary by a vocational expert to show what type of work the claimant can do. Certainly it could be argued that an adequately developed record would allow an Administrative Law Judge to make such a finding. Other considerations go to the question of whether the record can be adequately developed at an earlier stage of the proceedings. If it is true as the evidence seems to suggest that the assessment of the vocational factors at the initial determination level is being given inadequate consideration by many State agencies, perhaps some thought should be given to the development and adjudication of such cases at this stage in the proceeding by personnel under the direct control and supervision of the Federal Government. One possibility might be the expanding Bureau of Disability Insurance regional review staff for this purpose. Alternatively, better documentation of the vocational factors in the record could be developed by written interrogatories to vocational experts or through the use of specialized vocational studies.[5] Live vocational testimony is now being utilized in 25 percent of the disability cases at the hearings level and the upward trend in its use and the potential impact of the SSI program makes this a particularly crucial time for a study of this area. The Director of the Bureau of Hearings and Appeals is presently conducting a reevaluation of these procedures.

MEDICAL ADVISOR—HEARING PHASE

Although the primary focus of the following discussion will be on the use of medical consultants by Administrative Law Judges, some of the issues raised have relevance to physicians in other stages of the adjudicatory process and to their participation on teams or panels which make findings of disability under some of the alternatives proposed to the present system. Physicians are employed by the State agencies in the initial consideration and reconsideration phases of the proceedings as a member of a two-member team which makes the actual determination of disability.[6] (Probably it is more accurate to say that they review the determinations of the lay determiners and sign them if they are in accord). The medical advisors at the hearing level do not examine the claimant but they may base their observations and findings on "consultative" examinations made by other physicians under contract with the agencies or the Bureau of Hearings and Appeals and other medical evidence in the files.

Unlike the State agency "team" physicians, the medical advisors to the Administrative Law Judges are not supposed to have decisional authority. They act solely as expert witnesses. Their conduct and function has attracted the notice of the Harrison Subcommittee, the Supreme Court in the case of *Richardson* v. *Perales* (402 U.S. 387, 406), and Robert Dixon, Jr.

In 1960 Congressman Harrison was highly skeptical of the use of the medical consultant (now called advisors) and the fact that their existence and participation in the process was not reflected on the record (1960 hearings, p. 979). The report of the Harrison Subcommittee stated:

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[5] In fiscal 1973, interrogatories constituted only 2.8 percent of total vocational expert usage.

[6] Because of SSI workload problems the Bureau of Disability Insurance has authorized State agency physicians to undertake examinations of claimants but they cannot subsequently take part in the adjudication of the case.

> The opinions and comments of the consultants do not appear on the record of the hearing. In fact, the record does not indicate that such a consultation has been had. The representatives of the Department testified that these consultants are valuable for training purposes in helping examiners deal with difficult problems of medical evidence. However, the present method by which such consultants are used may conflict with section 5(c) of the Administrative Procedure Act, which states in part—
>
> "Save to the extent required for the disposition of ex parte matters as authorized by law, no such officer [hearing examiner] shall consult any person or party on any fact in issue unless upon notice and opportunity for all parties to participate. * * *"
>
> The Social Security Administration has advised the subcommittee that examiners will be "instructed" to use medical consultants for the following purposes:
>
> (1) for advice as to questions which should be asked at a hearing;
> (2) for information as to the type of details of a consultative examination;
> (3) for training sessions occasioned by a number of cases involving the same or similar impairments to be attended by all hearing examiners in the particular office.
>
> Otherwise, the Commissioner advises that analysis and comment by medical consultants will be made part of the hearing record.
>
> It is the conclusion of the subcommittee that such instructions if carried out would not answer all objections. The essential problem in the proposed instructions is that they would continue to allow close association between the examiner and the consultant in regard to specific cases. When the consultant can urge a particular line of questioning, or urge that certain types of evidence be obtained it is fiction to say he is not in a position to influence the examiner's decision. Further, so long as this association between examiner and consultant is not a matter of record, it will be impossible to determine whether the "consultation" has stayed within prescribed bounds. Therefore, the subcommittee is of the opinion that such medical consultants should be used in only two ways—(1) in general training sessions involving general questions and a group of examiners, or (2) as witnesses whose testimony appears in the record, or which can be made part of the record at the request of the claimant after notice in the record (pp. 35–36).

At this stage of the study the staff has no comprehensive idea of how medical advisors are being used at the hearing level.[7] It does seem that the physicians who do testify as experts are insulated from contact with the ALJ's prior to the hearings and their participation is clearly on the record.

Dixon, in one of the three hearings he attended, observed a medical advisor who made it virtually impossible, in his opinion, for the hearing examiner (now Administrative Law Judge) to come to a finding at odds with the physician's opinion. Dixon wrote that this medical advisor stated to him that "he had frequently seen cases completely 'turned around' by this kind of expert medical testimony; (the medical advisor) seemed to view such a result to be his mission" (p. 90). The following is Dixon's concluding commentary on the role of the medical advisor:

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[7] The Administration's brief in the *Perales* case gives the following explanation:

> The medical advisor often furnishes two somewhat distinct types of testimony at hearings. His more limited function is that of simply explaining the nature, and the significance of the results, of clinical and laboratory tests reported by other doctors. For example, Dr. Leavitt, the medical advisor here, testified to the nature of and technique involved in an electromyographic examination and explained the different types of graph readings that might be obtained from such examination and what their significance would be. He then explained the significance of the particular finds in the electromyographic examination reported by Dr. Mattson.
>
> In addition to such limited explanatory testimony, medical advisors sometimes give their own opinion of the claimant's condition—based on all the medical evidence in the case, both documentary and testimonial. As previously noted, Dr. Leavitt offered such an opinion in the present case (pp 38–39).

> The hearing examiner may request the presence of a medical advisor to perform the interpretative middleman role. When thus brought into the hearing as an expert witness, the medical advisor may become the "sleeper" in this decisional system. Chosen from a part-time panel, and operating outside the chain of command, he can nevertheless have the real power of decision if he wishes to seize it. He can support a conclusion of disability in such clear terms that the examiner will have little choice but to concur or face an appeal: a forthright negative statement would be equally hard to ignore. It would be anomalous and detrimental to the development of a rational, responsible, clarified law of disability to vest de facto decisional power in all close cases in an unofficial agent outside the discipline of the precedent system. The medical advisor role may not go that far, but it tends in that direction.
>
> As long as the present system is retained there is no easy answer to the problem of an irresponsible medical advisor who fails to realize that in the large number of borderline cases at the hearing examiner level disability is not a medical judgment but a legal conclusion. Even under *Richardson* v. *Perales*, however, it would be possible to revert to the former criticized and discarded system of ex parte consultation provided the medical opinion evidence were put in the record as part of the substantial evidence to be relied on in support of a decision and provided the medical expert were available for cross-examination on request of the claimant. Of course, if the reconsideration stage became the basic hearing stage, a physician could be included as a responsible member of the decisional panel (p. 149).

The Supreme Court in the *Perales* case, noting that medical advisors are used in about 13 percent of the hearings, saw "nothing unconstitutional or improper in the medical advisor concept" (p. 431). The dissent states, however, that "the use of circuit-riding doctors who never see or examine claimants to defeat their claims should be beneath the dignity of a great nation." The dissent further cites the circuit court judge to the effect that the way hearing officers parrot "almost word for word the conclusions" of the "medical advisor" produced "nausea" in him.

Even assuming that since *Perales* the use of medical advisors raises no constitutional issue, there remain some rather basic policy issues as to what is the proper role of the expert physician witness in the disability determination process. How can we be assured that they are testifying as "experts" and are not usurping decision-making functions? Even if Mr. Dixon's experience is unrepresentative of expert physician witnesses under the present system, are current organizational arrangements sufficient in controlling such propensities? Should we consider Dixon's suggestion of authorizing ex parte consultation again as long as there is notation in the record and a right of cross-examination by the claimant's representative? How would this mechanism be policed?

The primary finding in *Richardson* v. *Perales* was that the consultative examination by the physician contracted for by the State agency had evidential worth even though such physicians were not available for cross-examination at the hearings.[8] The Court adopted the argument in the Administration's brief that the administrative burden and expense of requiring the consultative physicians to testify in person might be large and might further discourage physicians from participating in the program. The Court stated: "With over 20,000 disability claims hearings annually, the cost of providing live medical testimony at those hearings, where need has not been demonstrated by a request for a subpena, over and above the cost of the examinations requested by hearing examiners, would be a substantial drain on the trust fund and on the energy of physicians already in short supply" (402 U.S. 387, 406). The claimant's brief in the case contained the following counter-argument:

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[8] The Court noted that the claimant had not taken advantage of the opportunity under the regulations to subpena the physicians who conducted the consultative examination. The Administration's brief states that "under the present practice, consultant physicians are required to testify only in relatively few cases in which a specific need for their testimony, sufficient to obtain a subpena, has been shown" (p. 25).

> The Social Security Administration tells us on one hand that they cannot find the funds to bring the doctors who have examined the man to testify and yet on the other hand can pay travel fees to fly these so-called "medical advisers" around the state and yet do not feel they should even have the claimant examined by the "medical advisers". It would seem far better if the Social Security Administration would spend this money on the doctors who have examined the claimant to come and testify rather than having doctors who have never examined the claimant come and give medical advice to a Hearing Examiner strictly on the basis of reports (p. 21).

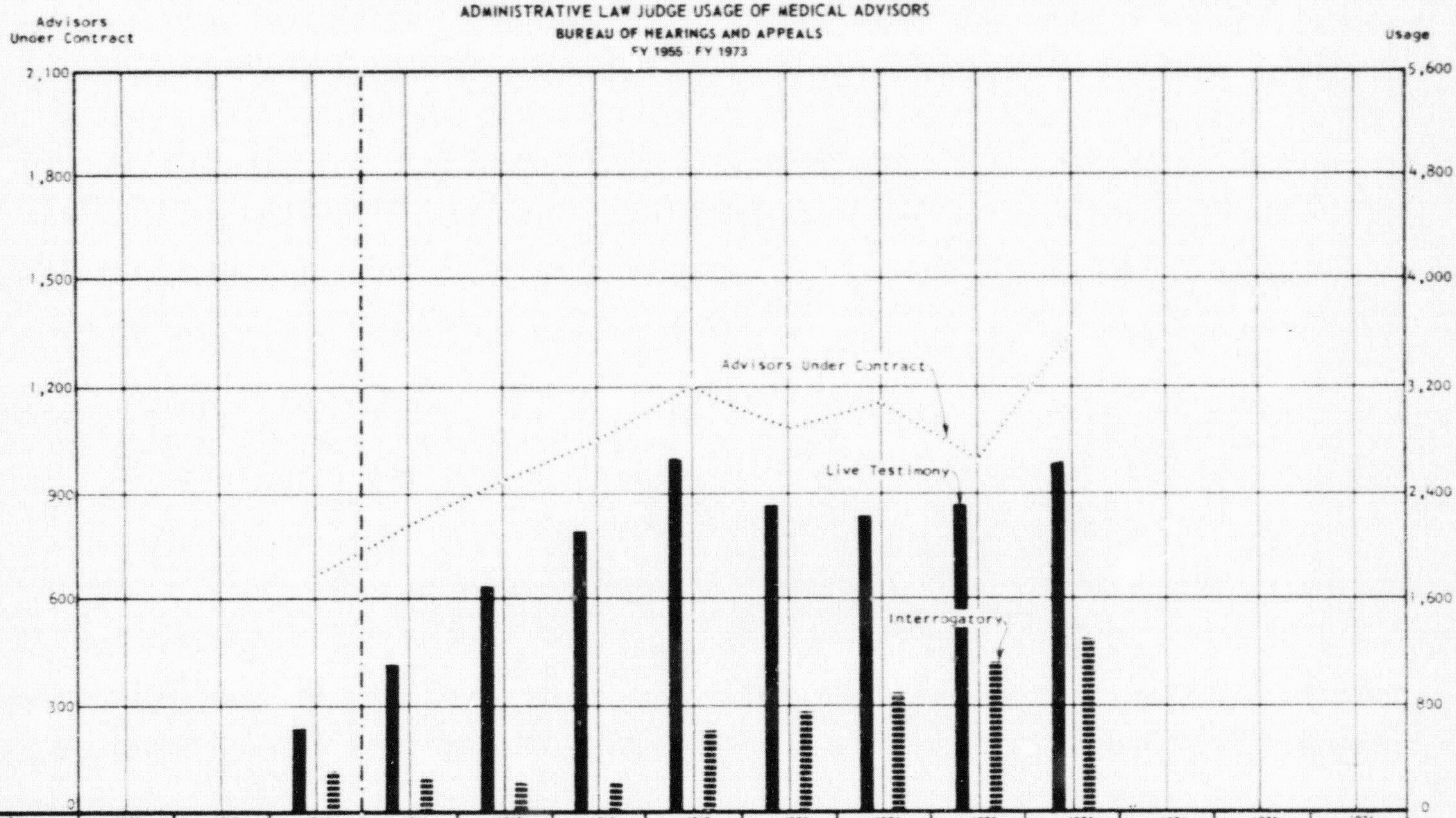
Interrogatories are used more frequently with medical advisors than with the vocational experts—one of every three usages in fiscal 1973 was by the interrogatory route—and this method has increased rather substantially over the last 5 years.

Finally, there again arises the question of the point in the procedure that medical expertise should be obtained and in what form it should be. In recent years the percentage of cases where the State agencies have purchased consultative medical examination has dropped from about 40 percent to about 20 percent. Moreover, recent communications to the States indicate a certain further deemphasis on the extent of medical documentation because of workload problems brought on by the implementation of Supplemental Security Income program. Does this mean that medical evaluation will be further pushed back on the hearing process with greater reliance placed on the medical advisor? It is doubtful that the medical advisor can make up for the lack of medical documentation at earlier decisional stages. It is even more questionable that they should be allowed or obliged to take on more decisional responsibility.

ADMINISTRATIVE LAW JUDGE USAGE OF MEDICAL ADVISORS

BUREAU OF HEARINGS AND APPEALS

FY 1955 FY 1973



CATEGORY	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
ADVISORS	--	--	664	803	938	1,052	1,201	1,087	1,134	1,016	1,331			
LIVE T'Y	--	--	631	1,102	1,689	2,093	2,650	2,310	2,223	2,296	2,622			
INTERROG'Y	--	--	327	244	219	220	601	760	878	1,117	1,309			
OTHER(a)	--	--	22	135	174	53	15	--	33	--	81			
TOT USAGE	--	--	980	1,481	2,082	2,366	3,266	3,070	3,134	3,413	4,012			

SOURCE: HA 570.1

(a) Claimant did not appear at scheduled hearing, hearing was postponed for good cause, etc.

Note: Category "Other" is not plotted here.

PART III.—BACKGROUND MATERIAL

A. LEGISLATIVE HISTORY

The Development of the Disability Program Under Old-Age Survivors Insurance, 1935–74

CONSIDERATIONS OF DISABILITY INSURANCE, 1935–39

(a) *The 1935 Report to the President of the Committee on Economic Security* [1]

This report recognized the problems of earnings lost during periods of disability, but specific consideration was not given to the problems of permanent and total disability.

(b) *The Final 1938 Report of the Advisory Council on Social Security to the Senate Committee on Finance* [2]

The Council recognized the desirability of providing benefits to an insured person who becomes totally and permanently disabled and to his dependents. However, a difference existed in the Council on the timing of the introduction of these benefits. Those in favor of immediate introduction argued that permanently disabled persons (except the blind) were the only category of permanent social casualties who receive no insurance or assistance under the Social Security Act, and that no other group was more completely dependent or in a more desperate economic situation. Those Council members in favor of further study before establishing disability benefits argued that costs were unpredictable and that the initiation of the new benefits should wait until probable total program costs could be more accurately projected. They also envisioned many difficult administrative problems of a character apart from the rest of the program, such as the necessity for a skilled staff to make disability determinations in each case and for intensive and sustained local investigation to prevent abuses.

(c) *The 1938 Annual Report of the Social Security Board to the President* [3]

In recommending changes in the Social Security Act, the Board gave considerable thought to whether the system should be expanded to include provisions for benefits to workers who become permanently and totally disabled, before reaching age 65, and to their dependents. Recognizing the difficult but not insuperable administrative problems and the increased cost of the provision, the Board made no positive recommendation. The Board did state that the extent of the increase in costs would depend upon the definition of disability, and that a strict definition at the beginning would keep costs within reasonable limits. Later, with experience, the definition could be made more liberal if this was considered socially desirable. It was suggested that any plan for permanent total disability insurance should have adequate provisions for hospitalization and other institutional care, and vocational rehabilitation.

(d) *The 1939 Report to the President on National Health by the Interdepartmental Committee to Coordinate Health and Welfare Activities* [4]

After a survey of the problems of disabled persons, the Committee concluded that wage earners and their families need protection against loss of income during periods of temporary or permanent disability. The Committee recommended the development of social insurance to replace in part wages lost during temporary or permanent disability. It suggested that insurance against permanent disability should be effected through a liberalization of the old-age insurance system, paying benefits at any time prior to age 65 to qualified workers who become permanently and totally disabled.

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[1] See hearings before the Committee on Ways and Means, 74th, Cong., 1st sess. (1935), on H.R. 4120, p. 17 et seq.

[2] See hearings relative to the Social Security Act Amendments of 1939 before the Committee on Ways and Means, vol. 1, p. 18 et seq.

[3] *Ibid*, p. 3 et seq.

[4] H. Doc. No. 120, 76th Cong., 1st sess. (1939).

(e) *Social Security Act Amendments of 1939*

There were no provisions on disability in the 1939 amendments to the Social Security Act; nor was any mention made of disability in the Committee reports accompanying the bill which later was enacted by the Congress.

CONSIDERATIONS OF DISABILITY INSURANCE, 1940–50

(a) *Annual reports of the Social Security Board from 1940 to 1950*

Throughout this period, the Social Security Board (and its successor, the Social Security Administration) recommended in its annual reports the payment of social insurance benefits to permanently and totally disabled persons. Some of the specific proposals made to implement this recommendation were as follows:

(1) Benefits should be payable only after a 6-month waiting period and then only if the disabled person had been in covered employment within a reasonably recent period, for a reasonably substantial time, and with reasonably substantial income.

(2) Benefits should be paid to dependents of disabled workers.

(3) Vocational rehabilitation for beneficiaries should be financed from the trust fund.

As for the definition of disability, the Board stated that for "permanent" disability to imply a concept of lifetime disability, requiring a medical prognosis of permanency, was socially and administratively unsatisfactory. Instead, benefits should be paid for loss of earnings after a suitable waiting period (6 months) and for the duration of total incapacity for substantially gainful work.

(b) *The 1946 Report to the Committee on Ways and Means by the Committee's social security technical staff* [5]

After an analysis of the problems involved in long-term disability benefits provided as an extension of OASI, this report—known as the Calhoun report—suggested as an initial step that such benefits be provided only to persons above some specified age, such as 55 or 60. It was felt that this would be a promising method for easing into disability insurance with a minimum of initial difficulty, although it was recognized that it would not touch the areas where the consequences of disability were the most serious.[6]

(c) *Social Security Act Amendments of 1946*

These amendments were limited in scope and dealt only with simple and noncontroversial legislative changes; they did not include a provision for disability insurance.

(d) *The 1948 Report of the Advisory Council on Social Security to the Senate Committee on Finance* [7]

The Council recommended payment of benefits to the permanently and totally disabled, regardless of age, as part of the social insurance system. (Two members of the Council disagreed with this recommendation. They felt that protection against the risk of total disability should be provided by State assistance programs aided by Federal grants and should not be included in a Federal contributory system.) Some of the specific recommendations of the Council were—

(1) A strict test of recent and substantial attachment to the labor market should be a condition of eligibility. The individual would need a

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[5] Issues in social security: A report to the Committee on Ways and Means of the House of Representatives by the committee's social security technical staff established pursuant to H. Res. 204 (79th Cong., 1st sess.), 1946.

[6] Ibid., p. 101. In its 1947 report, the Social Security Administration argued against the suggestion that benefits be limited to disabled workers over age 55 by emphasizing that the consequences of disability may be more disastrous for the younger than the older worker. See annual report of the Federal Security Agency (1947), pp. 62 and 63.

[7] S. Doc. No. 162, 80th Cong., 1st sess. (1948).

minimum of 40 quarters of coverage, at least 1 quarter of coverage for every 2 calendar quarters in his working lifetime before the onset of disability, at least 6 quarters of coverage in the 12 quarters preceding such onset, and at least 2 quarters of coverage in the 4 quarters preceding such onset.

(2) The definition of disability would mean "any disability which is medically demonstrable by objective tests, which prevents the worker from performing any substantially gainful activity, and which is likely to be of long-continued and indefinite duration." [8]

(3) Qualified individuals would be eligible for benefits after a waiting period of 6 months. Such a waiting period was recommended "because it is sufficiently long to permit most essentially temporary conditions to clear up or show definite signs of probable recovery." [9]

(4) No benefits would be provided for dependents.

(5) Benefits would be suspended where workmen's compensation was payable; if another Federal program paid a disability benefit, only the larger benefit would be paid. It was felt that dual benefits based on disability would be so high as to discourage beneficiaries from returning to gainful work when they are able to do so.[10]

(6) The provisions for disability benefits and for old-age and survivors benefits would be so integrated that periods of total disability would not be counted in computing insured status and the average monthly wage of a disabled person.

(7) Rehabilitation services would be provided and paid from the trust fund.

SOCIAL SECURITY ACT AMENDMENTS OF 1950

Many of the details of the present disability program had their origin in the bill, H.R. 6000, which eventually became the 1950 amendments to the Social Security Act. This bill, as passed by the House of Representatives late in 1949, contained provisions for the payment of disability insurance benefits under title II of the Social Security Act to permanently and totally disabled insured workers. In support of its action recommending such a program to the House of Representatives, the Committee on Ways and Means relied upon the recommendations of the 1948 Advisory Council. In the view of the committee, the program it recommended was conservative inasmuch as it:

> would only apply to those wage earners and self-employed persons who have been regular and recent members of the labor force and who can no longer continue gainful work.[11]

The Senate, however, deleted the disability insurance provisions when it passed H.R. 6000. In its report on H.R. 6000, the Senate Committee on Finance expressed the following views on the disability insurance program:

> Your committee has not included permanent and total disability insurance or assistance provisions in the bill. We recognize that the problem of disabled workers is one which requires careful attention, especially because of the increasing proportion of older workers and the rising rate of chronic invalidity in the population. Moreover, the problem is not limited to the feasibility of providing income or pensions merely to maintain disabled workers. At least of equal significance is the need for assuring fullest use of rehabilitation facilities so that disabled persons may be returned to gainful work, whenever this is possible. Your committee believes that the Federal Government should increase the grants-in-aid to the States for vocational rehabilitation and that further study should be made of the problem of income maintenance for permanently and totally disabled persons.[12]

The conference committee went along with the Senate version of the bill as to disability insurance benefits, and as finally passed by the Congress the bill made no provision for disability insurance benefits. The legislation did, however, extend the State-Federal public assistance programs to the permanently and totally disabled by providing grants-in-aid to the States for such individuals who are in need, as had been recommended by the minority of the 1948 Advisory Council.[13]

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[8] Ibid., p. 5.

[9] Ibid., p. 7.

[10] Ibid., p. 9.

[11] H. Rept. No. 1300, 81st Cong., 1st sess. (1949), pp. 27 and 28.

[12] S. Rept. No. 1669, 81st Cong., 2d sess. (1950), p. 3.

Some of the salient features of the disability insurance program passed by the House of Representatives as part of H.R. 6000 were—

(1) To be insured, the individual needed 20 quarters of coverage in the 40-quarter period ending with the quarter of disablement and 6 quarters of coverage in the 13-quarter period ending with such quarter.

(2) The definition of disability was the same as the present definition for the payment of disability insurance benefits, except that the disability had to be "medically demonstrable" and "permanent," and blindness (defined as it now is for purposes of the disability "freeze") was included within the definition. Benefits were to be paid only after a waiting period of 6 months. In this regard the Committee on Ways and Means made it clear that the 6-month period was not a basis for a presumption of permanence or protracted total disability. Where recovery could be expected, according to medical prognosis, within relatively short periods of time after the expiration of the 6-month waiting period, such cases would not be compensable under the definition of disability. The committee felt that a cautious approach to the payment of benefits was necessary to prevent abuses.[14]

(3) There was no age limitation such as the former requirement that an individual must be at least age 50 to receive benefits; nor was provision made for the payment of benefits to dependents.

(4) An individual's insured status and benefit amount for purposes of old-age and survivors insurance were preserved (i.e., a disability "freeze" was established) while he was entitled to disability insurance benefits.

(5) Determinations of disability were to be made by the Administrator of the Federal Security Agency (predecessor of the Secretary of Health, Education, and Welfare).

(6) Benefits were to be adjusted in cases where the beneficiary was also receiving a workmen's compensation benefit for the same disability during the same period of time.

(7) Benefits were to be suspended where, among other things, an individual who was still disabled had earnings in excess of a permitted amount or where he failed, without good cause, to accept certain rehabilitation services or to undergo medical examinations.

SOCIAL SECURITY ACT AMENDMENTS OF 1952

The 1952 amendments to the Social Security Act provided for a disability "freeze" (not disability insurance benefits) with an effective date of July 1, 1953, but only if the Congress prior to that date affirmatively approved the provision. The Congress did not take any action prior to July 1, 1953. As a result, the disability "freeze" in the 1952 amendments never became operative.

The 1952 amendments had their origin in H.R. 7800, which was reported out by the Committee on Ways and Means of the House of Representatives with a provision for a disability "freeze" similar in many respects to the disability "freeze" in present law. The committee included in the bill a provision which authorized the Administrator of the Federal Security Agency to make determinations of disability—a like provision having appeared in H.R. 6000 as passed by the House of Representatives in 1949. This provision came under heavy attack on the floor of the House of Representatives[15] and was eventually deleted from the bill. As finally passed by the House of Representatives, the bill contained no specific provision as to who would make determinations of disability.

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[13] Title XIV, Social Security Act, superseded by new title XVI under Public Law 92-603

[14] H. Rept. No. 1300, 81st Cong., 1st sess. (1949), pp. 29 and 30.

[15] Congressional Record, vol. 98, p. 5466 et seq. (May 19, 1952).

The Senate Committee on Finance recommended the passage of H.R. 7800 without any provision for a disability "freeze." In taking this action, the committee stated:

> In deleting these provisions, your committee did not prejudge the merits of these proposals. There was insufficient time for full hearings which would have been necessary if proper consideration were given to these two provisions and the numerous amendments suggested thereto.[16]

The Senate followed the recommendations of the Committee on Finance.

In conference, it was agreed to recommend the inclusion of the disability "freeze" as passed by the House of Representatives with the following two notable changes—(1) determinations of disability would be made by States through appropriate agencies pursuant to agreements between the States and the Administrator; and (2) the provision would become operative only if Congress later affirmatively approved it.[17]

Although the disability "freeze" in the 1952 amendments never went into effect, its specific provisions later served as a basis for the disability "freeze" enacted in the 1954 amendments.

SOCIAL SECURITY AMENDMENTS OF 1954

These amendments established the first operating disability program under the Social Security Act.

The definition of "disability" was basically the same as the definition which appeared in H.R. 6000 as passed by the House of Representatives in 1949.

The insured status requirements for a "freeze" were 20 quarters of coverage in the 40-quarter period ending with the quarter of disablement and 6 quarters of coverage in the 13-quarter period ending with such quarter—the same as appeared in H.R. 6000 as passed by the House of Representatives in 1949. (Under present law, the "20-out-of-40" requirement still generally exists, while the "6-out-of-13" requirement was repealed in 1958.)

As under present law, the "freeze" was retroactive to the date of onset of disability, which could be as early as the fourth quarter of 1941. The law provided, however, that retroactivity could exceed no more than 12 months if the application was filed after June 30, 1957.

In addition, Congress, recognizing the importance of rehabilitating disabled persons, specifically provided for the referral of such persons to State rehabilitation agencies for rehabilitation services so that the maximum number of disabled individuals may be restored to productive activity.

In all other respects (State determinations and effect of freeze) the law enacted in 1954 is the same as present law.

In moving from determinations of disability made by the Federal Government (as provided in H.R. 6000 passed by the House of Representatives in 1949) to State determinations (as first promulgated in the inoperative 1952 provision), the Committee on Ways and Means stated:

> By and large, determinations of disability will be made by State agencies administering plans approved under the Vocational Rehabilitation Act. This would serve the dual purpose of encouraging rehabilitation contacts by disabled persons and would offer the advantages of the medical and vocational care development undertaken routinely by the rehabilitation agencies. These agencies have well-established relationships with the medical profession and would remove the major load of case development from the Department.
>
> By agreement, the State agencies will apply the standards developed for evaluating severity of impairments for purposes of the

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[16] S. Rept. No. 1806, 82d Cong., 2d sess. (1952), p. 2.

[17] The purpose of this, according to the conference committee, was to "permit appropriate steps to be taken for the working out of tentative agreements with the States for possible administration of the disability provisions" and to allow further hearings to be held. H. Rept. 2491, 82d Cong., 2d sess. (1952), p. 9.

freeze. This will promote equal treatment of all disabled individuals under the old-age and survivors insurance system in all States. The cost to these agencies for their services in making disability determinations will be met out of the Trust Fund.[18]

SOCIAL SECURITY AMENDMENTS OF 1956

Monthly disability insurance benefits were provided under the 1956 amendments to eligible disabled workers between the ages of 50 and 65. In addition, benefits were provided for disabled dependent children of a retired or deceased insured worker if the child was disabled before he attained the age of 18.

These changes in the Social Security Act were first included by the Committee on Ways and Means in H.R. 7225, the bill which later became the 1956 amendments to the Social Security Act. The provisions relating to the disabled insured workers were patterned after the provisions on disability appearing in H.R. 6000 as passed by the House of Representatives in 1949, except that benefits were to be paid only to individuals between the ages of 50 and 65. The provisions in the bill relating to childhood disability benefits were somewhat restrictive in that they applied only if the child was on the benefit rolls prior to attainment of age 18. H.R. 7225 was passed by the House of Representatives in 1955.

The Senate Committee on Finance, which held hearings on the bill in 1956, recognized the problems of the severely disabled worker but did not agree that disability insurance benefits should be provided under the old-age and survivors insurance system. This was the position taken by Secretary of Health, Education, and Welfare Folsom, in testifying before the committee. The committee, in opposing a cash disability insurance benefit program, considered: (1) The difficulty in making disability determinations, (2) the availability of assistance under the program of aid to the permanently and totally disabled, (3) the significant strides made in vocational rehabilitation, (4) the uncertainty as to the future costs of a cash disability insurance benefit program, and (5) the need for time to study and evaluate existing disability programs.[19]

It did, however, recommend the adoption of the provisions relating to the payment of childhood disability benefits, except that it removed the restriction that the child must be on the benefit rolls prior to attainment of 18; it sufficed that the child became disabled before 18. So long as that occurred, the childhood disability benefit would be paid to the child whenever the insured worker died or became entitled to old-age insurance benefits. The committee did not believe that the serious difficulties involved in paying benefits to disabled workers applied to children disabled before age 18, since most of the cases involving children would be the result of congenital conditions or conditions existing since early childhood, including mental deficiency.[20]

When H.R. 7225 was acted upon by the Senate, an amendment providing for disability insurance benefits was adopted on the floor by a 47 to 45 vote. The amendment followed very closely the provision adopted by the House of Representatives in the preceding year with one notable exception—a separate trust fund was set up for the purpose of paying disability insurance benefits. This fund is held separate from the trust fund from which other benefits are paid and is the only source from which disability insurance benefits can be paid. The rate of contributions to this fund was one-half of 1 percent on wages (an employer rate of one-fourth of 1 percent and an employee rate of one-fourth of 1 percent) and three-eighths of 1 percent on the earnings of the self-employed.

In conference it was agreed to adopt the Senate's version of the disability insurance program with its separate trust fund, including the more liberal provision for the payment of childhood disability benefits.

As passed in 1956, the following pertinent provisions appeared:

(1) Benefits were payable if the individual was insured, was between the ages of 50 and 65, was under a disability, and had applied for benefits.

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[18] H. Rept. 1698, 83d Cong., 2d sess. (1954), pp. 23 and 24.

[19] S. Rept. 2133, 84th Cong., 2d sess. (1956), pp. 3 and 4.

[20] Ibid., p. 2.

Benefits were payable beginning July 1957, and, except in the case of applications filed before January 1958, there was retroactivity of benefit payments.

(2) Insured status provision: The individual must have been a currently insured individual (a requirement similar to the one then existing under the "freeze" of 6 quarters of coverage in the 13 quarters ending with the quarter of disablement) and he must have had 20 quarters of coverage out of the last 40 calendar quarters.

(3) The definition of disability stated that in order for a person to be under a disability he must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which must be expected to result in death or to be of long-continued and indefinite duration. The definition for "blindness" was similar to that of the freeze except that a blind person had to meet the substantial gainful activity test.

(4) There must have been 6 months of disability before benefits could be paid.

(5) Disability insurance benefits were reduced in any case where the individual was receiving another Federal disability benefit or a State workmen's compensation payment.

(6) In addition to the provision on rehabilitation enacted as part of the 1954 amendments, further provision on rehabilitation were added, those dealing with the withholding of benefits for refusing rehabilitation services and the rendering of services under a State plan for vocational rehabilitation.

(7) The provisions relating to the definition of disability, rehabilitation, and reduction as applied to disabled insured workers were also applicable to childhood disability benefits.

(8) Determinations of disability were to be made by the States under the same conditions as determinations of disability were made under the freeze.

The Conference report also stated:

> it is understood and expected that the Secretary of Health, Education, and Welfare will fully utilize his authority to review and revise determinations of State agencies in order to assure uniform administration of the disability benefits and to protect the Federal Disability Insurance Trust Fund from unwarranted costs.[21]

AMENDMENTS TO THE SOCIAL SECURITY ACT IN 1957 (PUBLIC LAW 85–109)

These amendments (Public Law 85–109) made the following changes:

(1) The 12-month limitation on retroactivity of the disability "freeze" did not apply if the application were filed prior to July 1, 1957. The 1957 amendments extended this date to July 1, 1958. The Committee on Ways and Means indicated concern:

> that many persons who became disabled some time ago will, if they fail to file applications before July 1, 1957, lose all their protection under the old-age and survivors insurance program * * * it is only fair to give workers now disabled a further opportunity to avoid loss of these valuable rights * * *.[22]

(2) Disability insurance benefits were reduced where the beneficiary was receiving a disability benefit under another Federal program. The 1957 amendments exempted from this provision veterans' compensation received on account of service-connected disabilities. According to the Committee on Ways and Means—

> the purpose of veterans' compensation is such as to justify disregard of that compensation in the determination of rights to disability insurance benefits under the social security program.[23]

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[21] H. Rept. 2936, 84th Cong., p. 26.

[22] H. Rept. 277, 85th Cong., 1st sess. (1957), p. 2.

[23] Ibid., pp. 2 and 3.

SOCIAL SECURITY AMENDMENTS OF 1958

The 1958 amendments broadened the protection of the disability program and removed certain provisions which had proved unnecessary and, in some situations, had caused inequities. The following modifications were made:

(1) Provision was made for the payment of monthly benefits to dependents of disability insurance beneficiaries.

(2) The amendments repealed the provision (known as the offset) which required the reduction of disability benefits where the beneficiary was receiving a workmen's compensation payment or a disability benefit from another Federal program. The Committee on Ways and Means expressed the view that the "danger that duplication of disability benefits might produce undesirable results is not of sufficient importance to justify reduction of social security disability benefits." [24]

(3) Applications for disability benefits were made retroactive for as much as 12 months to prevent the loss of benefits where a beneficiary fails to file a timely application. [25] For a similar reason, the deadline date for full retroactivity in the case of a disability "freeze" was extended from July 1, 1958, to July 1, 1961,—applications for the freeze filed on or after July 1, 1961, were made retroactive for not more than 18 months.

(4) The insured status requirements for the disability "freeze" and disability insurance benefits were modified and made identical. The modification was the elimination of a recency-of-work test—i.e., the requirement of currently insured status for disability benefits and of "6 quarters of coverage out of 13 quarters" for the disability "freeze". The test was made identical by adding the requirement of a fully insured status for the "freeze." (In the 1956 amendments, "fully insured status" was included as a requirement for disability insurance benefits.)

The Committee on Ways and Means felt that the elimination of this recency-of-work test would be particularly helpful to persons with progressive illnesses. In many such cases, a person who is forced to stop working as a result of his impairment would lose his insured status before the impairment became sufficiently severe to meet the statutory definition of disability. The committee also felt that the fully insured status requirement was necessary for the disability "freeze" in order to avoid the anomalous situations that might arise after June 1961 with respect to workers who could qualify for a disability freeze and not be eligible for any disability or old-age benefits. [26]

SOCIAL SECURITY AMENDMENTS OF 1960 (PUBLIC LAW 86-778)

These amendments removed the minimum age requirement of 50 years for the purpose of disability benefits for insured workers. The report of the Subcommittee on the Administration of Social Security Laws of the Committee on Ways and Means, which was issued in 1960, stated:

> During the course of the hearings the question of the desirability of removing the age requirement, and the administrative ramifications which such a change would entail, came up time after time (e.g. hearings, pp. 70, 83-839, 858, 918, 922-924, 964, 975).
>
> The evidence before the subcommittee was:
>
> 1. There is no administrative or other justification for continuation of this purely arbitrary distinction.
>
> 2. The distinction can be eliminated without an increase of the tax or impairment of the soundness of the trust fund, according to the Department of Health, Education, and Welfare.[27]

There were also a number of recommendations from a GAO study on the disability program which found great support in the subcommittee hearing and were incorporated into the 1960 legislation. Included among these were:

1. A trial work period in order to encourage attempts by disabled workers to return to the labor market. Under this provision a disabled person, provided

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[24] H. Rept. 2288, 85th Cong., 2d sess. (1958), p. 13.

[25] Ibid., pp. 13 and 14.

[26] Ibid., pp. 14 and 15.

[27] Preliminary Report of Committee on Ways and Means, Mar. 11, 1960, p. 46.

his disability has not medically improved, may return to work for up to 9 months, not necessarily consecutively, and still receive benefits. If at the end of this 9-month trial work period the worker is found to be able to engage in substantial gainful activity, his benefits are terminated in 3 months. Thus, a disable worker may experiment with his vocational skills up to a year without losing his eligibility for benefits. No trial work period, however, was provided within 5 years following the termination of a period of disability.

2. Elimination of the 6-month waiting period for a disability which recurs after an apparent recovery, as an incentive to encourage disabled workers to return to work. The time elapsed between periods of disability may not exceed 60 months. Thus, a disabled worker may return to the job market if his condition improves knowing that if his condition worsens he will receive immediate help without the waiting period.

PUBLIC LAW 88-650 (1964)

In 1964 the restriction on retroactivity of disability applications was eliminated. Before this amendment the beginning of a period of disability could not be established earlier than 18 months before an application was filed.

SOCIAL SECURITY AMENDMENTS OF 1965 (PUBLIC LAW 89-97)

In these amendments the qualifying duration of a disability was liberalized so that a worker would become entitled to benefits if his disability could be expected to last for a continuous period of 12 months or longer instead of the previous requirement of "long-continued and indefinite duration." The Senate Committee on Finance's report stated that:

> The effect of the provision the committee is recommending is to provide disability benefits for a totally disabled worker even though his condition may be expected to improve after a year. As experience under the disability program has demonstrated, in the great majority of cases in which total disability continues for at least a year the disability is essentially permanent * * *.
>
> It is estimated that if benefits were payable for disabilities that are total and last more than 12 calendar months but are not necessarily expected to last indefinitely, about 60,000 additional people—workers and their dependents—would become immediately eligible fo benefits.[28]

This provision brought the program more in line with commercial disability insurance policies.

A provision was also included in the legislation which permitted young workers who were blind to qualify even though they had not worked for a substantial period of time. The amendment provided that a blind worker under 31 need have insurance coverage for only one-half of the quarters between age 21 and the time he became qualified for disability benefits. He must, however, have a minimum of six quarters of coverage. (Prior law provided that all workers including the blind, must have worked 5 years out of the last 10 preceding their disability.) The amendments also modified the definition of disability for a person 55 or older who became blind from one requiring inability to engage in any substantial gainful activity to one requiring skills and abilities comparable to those used in his previous work experience. Previously, the substantial gainful activity criteria were applied to blind persons of all ages.

The House Committee on Ways and Means requested in its report on the 1965 amendments that a study be done to determine if workers receiving both State workmen's compensation benefits and disability benefits are receiving excessive payments. The Senate Committee on Finance, however, felt that it was desirable to add an offset provision for workmen's compensation without waiting for the study. This amendment, as it was included in the law, allowed an individual who was entitled to receive State workmen's compensation and federal disability benefits to receive both in full if they do not together exceed the higher of:

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[28] S. Rept. No. 404, part I, 89th Cong., p. 99.

> 80 percentum of his "average current earnings", or the total of such individual's disability insurance benefits * * *. For purposes of [this] clause, an individual's average current earnings means the larger of (A) the average monthly wage for purposes of computing his benefits under section 223, or (B) one-sixtieth of the total of his wages and self-employment income for the five consecutive calendar years after 1950 for which such wages and self-employment income was highest.[29]

An individual is permitted to receive any increase in social security benefits that Congress may authorize after the individual's offset was first applicable. This system for calculating the amount of reduction for disability benefits was designed to eliminate the problems caused by the dollar-for-dollar reduction included in the 1956 amendments, which caused its repeal in 1958.

In another area Congress tried to solve the dilemma of a worker who had to choose between either receiving an actuarially reduced old-age insurance benefit and, therefore, providing his wife, age 65 or over, with hospital insurance coverage or protecting his eligibility for disability payments. Under the provision a worker under 65 who becomes entitled to reduced retirement benefits retains his eligibility for disability insurance benefits.

When Congress established the disability program it stated that one of its objectives was to promote the rehabilitation of disabled insurance beneficiaries. To this end, applicants for disability insurance benefits were referred to the State vocational rehabilitation agencies. The Senate Committee on Finance's report stated that only about 3,000 disability beneficiaries were rehabilitated annually due in large part to the States' inability to match the Federal funds available for vocational rehabilitation. The 1965 amendment authorized social security trust funds to be made available to reimburse State vocational rehabilitation agencies for the cost of vocational rehabilitation services furnished to disability insurance beneficiaries. The total funds available could not, in any year, exceed 1 percent of the social security disability benefits in the previous year. It was felt that this expense would actually result in a savings for the trust fund since benefits for rehabilitated workers would be terminated and these workers would resume contributing to the trust fund through covered employment.

These amendments also changed section 223(b) of the Social Security Act to add a "floating application" clause. An application filed before a claimant is entitled to benefits is deemed to be filed at the time the claimant becomes eligible if he becomes entitled before the Secretary makes a final decision on his application. Thus, the onset date for a disability may be established after the date of application. Previous law allowed a claim to remain valid if the applicant could establish entitlement within 9 months of filing date only.

This law also included a provision for setting attorney's fees in social security cases before a Federal court. A judge who handed down a judgement favorable to the claimant in a disability case was authorized to determine a reasonable fee for such services before the court, not to exceed 25 percent of the claimant's past-due benefits. This provision originated as an administration proposal to protect the claimant against contingency agreements that allowed the lawyer to collect an unreasonably high percent of the claimant's benefit.

SOCIAL SECURITY AMENDMENTS OF 1967 (PUBLIC LAW 90–248)

In 1967 the Congress, in the context of major actuarial deficiencies in the disability insurance program, took up the problem of court interpretation of the disability definition. The Committee on Ways and Means' report noted that over the prior 4 years the number of disability allowances had been greater than estimated. Although the Social Security Administration had maintained that this was in large part due to greater knowledge of the availability of benefits and the better development of evidence of disability and its evaluation, the committee was particularly concerned with the "growing body of court interpretation of the statute which, if followed in the administration of the disability provisions, could result in substantial further increases in costs in the future." [30] The statutory definition of disability was expanded from its barebones statement of "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment" to the following:

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[29] Social Security Act, sec. 224(a).

> An individual * * * shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.[31]

The definition, as enacted into law, was almost identical to HEW policy as it appeared in the regulation or in the then confidential Disability Insurance State Manual. The Senate, by floor amendment, struck the Ways and Means provision, but the House provision was retained by the Conference Committee with the following elaboration of what is meant by the "work which exists in the national economy." The Conference report added the language that this term "means work which exists in significant numbers either in the region where such individual lives or in several regions of the country." The Statement of managers in the report said, "The purpose of so defining the phrase is to preclude from the disability determination consideration of a type or types of jobs that exist only in very limited numbers or in relatively few geographic locations, in order to assure that an individual is not denied benefits on the basis of the presence in the economy of isolated jobs he could do."[32]

The committee reports said they were presenting guidelines "to reemphasize the predominant importance of medical factors in the disability determination." The law was changed to read:

> For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.[33]

And both committee reports declared:

> Statements of the applicant or conclusions of others with respect to the nature and extent of impairment or disability do not establish the existence of disability . . . unless they are supported by clinical or laboratory findings or other medically acceptable evidence confirming such statements or conclusions". [34]

Finally, the legislation gave the Secretary specific regulatory authority to prescribe the criteria for determining when earnings derived from work demonstrate an individual's ability to engage in substantial gainful activity.

To provide younger workers who would normally not be expected to have enough quarters to qualify for benefits with protection, Congress extended the requirements for quarters of coverage for the blind under 31 to all workers of that age. A worker under 31 must have coverage for one half of the quarters between age 21 and the time he becomes disabled, with a minimum of six quarters.

A benefit was provided for disabled widows, aged 50 to 59 and disabled dependent widowers aged 50–61. The benefit was to be actuarially reduced according to the age of the beneficiary at the time of eligibility. To be eligible for the benefits, the widow or widower must have become totally disabled not later than 7 years after the spouse's death, or in the case of a widowed mother, before the end of her benefits as a mother or within 7 years thereafter. These 7 years provided the widow or widower with enough time to earn quarters of coverage to gain protection on his or her own record. However, the definition of disability for a widow, surviving divorced wife or widower was narrowed. In order to be found disabled, the above dependents must have a physical or mental impairment that is of such severity that it precludes the individual from engaging in any gainful activity. The test is based on the medical severity of the impairment and is not based on non-medical factors and work activity. No trial work period was provided for disabled widows and widowers.

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[30] H. Rept. 544, 90th Cong., p. 28.

[31] Social Security Act, sec. 223(d)(2)(A).

[32] H. Rept. 1030, 90th Cong., p. 52.

[33] Social Security Act, sec. 223(d)(3).

[34] H. Rept. No. 544, 90th Cong., p. 30.

The Senate Finance Committee added an amendment which changed the definition of blindness from "central visual acuity of 5/200 or less" to "central visual acuity of 20/200 or less." This new definition conforms to the definition of industrial blindness and enabled people who are industrially blind to qualify automatically for a social security earnings records freeze. In order to qualify for benefits, though, the blind person still had to prove inability to engage in substantital gainful activity.

The workmen's compensation offset was modified. Previous law did not take into account that some workers' creditable earnings for social security were only a part of their actual total earnings, and they may be getting less than 80 percent of the total predisability income. The new provision took into account the earnings of a worker which were in excess of those credited for social security purposes by providing that "average current earnings" could also be computed as one-sixtieth of the worker's total earnings over a specified 5-year period.

For purposes of the disability freeze, an extension of the time allowed to file was authorized. If an application for the freeze is filed not more than 12 months after the month in which the Social Security Amendments of 1967 were enacted, and if the disability ended not more than 36 months previous to the application; the freeze will be granted if, in accordance with the rules and regulations by the Secretary, the lapsed time was due to the worker's physical or mental condition.

A provision pertaining to attorney fees was passed on the Senate floor and adopted by the Conference. It authorized the Secretary of HEW to certify for payment a fee for services in administrative proceedings which result in a favorable outcome for the claimant. The amount certified for the fee could not exceed the smaller of (1) 25 percent of the past-due benefits, (2) the fee fixed by the Secretary, and (3) the fee agreed upon by the applicant and the attorney. The Secretary retained his authority to set fees according to how much time the attorney spent on the case and how difficult it was to prepare and argue.

SOCIAL SECURITY AMENDMENTS OF 1972 (PUBLIC LAW 92-603)

The amendments of this year were part of the comprehensive welfare-social security bill, H.R. 1. This bill was passed by the House on June 22, 1971, and by the Senate on October 6, 1972. Most of the lengthy debate on the bill was concerned with the welfare reform aspects rather than the disability program. However, the legislation did contain some new provisions for the disability program.

The waiting period required before a benefit could be paid was reduced from 6 to 5 months.

The recency of work requirement (20 quarters of coverage in the last 40-quarter period preceding disability) was eliminated for a blind person. The blind worker must now have as many quarters of coverage as the number of calendar years that have elapsed after 1950 or the year he reached 21, whichever is later.

Under previous law a worker's social security disability benefit was reduced if the disability benefit and any workmen's compensation benefit received exceeded 80 percent of the workers' average current earnings. The new law provided an additional method for computing the average current earnings. It can now be based on the highest 1 year of total earnings (not limited to earnings creditable for social security purposes), in the period consisting of the year of onset of disability and the 5 preceding years. It was felt that these earnings would perhaps be higher than earlier ones because of inflation.

Childhood disability benefits may be paid to an adult if the childhood disability began before age 22 instead of age 18 (as provided by previous law). In addition, a person who was entitled to childhood disability benefits will become reentitled if he again becomes disabled within 7 years after his prior entitlement to such benefits was terminated. This provision was included to encourage the person with a childhood disability to experiment with skills without losing entitlement to benefits. Applications for disability insurance benefits may be filed within 3 months after worker's death. Reimbursement from the Disability Trust Funds for vocational rehabilitation was increased in two stages—to 1.25 percent of the trust fund in fiscal year 1973 and to 1.5 percent of the trust fund in fiscal year 1974.

Several other laws also affect disabled persons and the social security disability system. They are as follows:

FEDERAL COAL MINE HEALTH AND SAFETY ACT OF 1969—BLACK LUNG

During consideration of the Federal Coal Mine Health and Safety Act, it was brought out in hearings that not more than a handful of States recognize pneumoconiosis (black lung) as a disease which would make miners eligible for workmen's compensation. Moreover, in States where this disease was recognized the standards for diagnosis were very strict. In the hearings before the Select Subcommittee on Labor of the House Committee on Education and Labor on H.R. 11476 in June and July of 1969, page 9, representatives of the United Mine Workers of America stated that since 1949 only six cases of pneumoconiosis had been awarded workmen's compensation benefits in West Virginia, and in all of these cases awards were granted only because autopsies showed that all had died from heart failure due to massive concentrations of coal dust in the lungs.

Legislation to compensate the Nation's miners from black lung, under Federal auspices, was developed in both Houses of Congress. The Senate amendment for disability benefits was introduced on the floor. It called for the Secretary of HEW to develop interim standards for "black lung" disability; however, the bill clearly intended benefits for complicated pnuemoconiosis only. The Secretary was then to enter into agreements with the States to receive and adjudicate black lung claims based on the disability standards published. The Federal Government was to pay all black lung benefits through fiscal year 1971. The States were to assume half of the burden in fiscal year 1972 and fiscal year 1973. After that time the Federal Government would be out of the program. A provision for benefits for widows and dependents was also included in the Senate bill.

The House version was reported out of the House Education and Labor Committee. It also called for payments to be made to miners who had complicated pneumoconiosis only. The Secretary of Labor was to enter into agreements with State governors in order for the States to process and adjudicate claims. The Secretary of Labor would make grants to the States to pay the claims. If an agreement could not be reached with any State the Secretary would pay the claim directly. No claim could be considered unless it was filed within 1 year after an employed miner received his first chest x-ray or was afforded an opportunity to have one. A system for giving every miner a chest x-ray every 6 months was established by the bill. An unemployed miner would have to file for benefits within 3 years after enactment, a widow 1 year after her husband's death. These time limits were meant to restrict payments to miners who already had pneumoconiosis rather than future victims.

In conference it was decided that this program could best be administered by the Secretary of HEW using "the personnel and procedures he uses in determining entitlement to disability insurance benefit payments under section 223 of the Social Security Act."[35] By regulation, disability decisions for black lung payments were made only in the central office in Baltimore instead of the State Federal decisionmaking system used for the regular section 223 disability cases. Evidence for black lung was gathered at the State level. Thus, the

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[35] Federal Coal Mine Health and Safety Act, sec 413(b).

Secretary of HEW had ultimate responsibility for the program, the so-called part B payments. Under the law, as it was passed, the Secretary of HEW was to publish regulations for determining disability under black lung. He was given the following guidelines for such regulation:

> 1. if a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more underground coal mines, there shall be a rebuttable presumption that his pneumoconiosis arose out of such employment;
>
> 2. if a deceased miner was employed for 10 years or more in one or more underground coal mines and died from a respirable disease, there shall be a rebuttable presumption that his death was due to pneumoconiosis; and
>
> 3. if a miner is suffering or suffered from a chronic dust disease of the lung which (A) when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization, (B) when diagnosed by biopsy or autopsy, yields massive lesions in the lung, or (C) when diagnosis is made by other means, would be a condition which could reasonably be expected to yield results described in clause (A) or (B) if diagnosis had been made in the manner prescribed in clause (A) or (B), then there shall be an irrebuttable presumption that he is totally disabled due to pneumoconiosis or that his death was due to pneumoconiosis, as the case may be.[36]

In order to be eligible for the Federal benefits, the miner must have filed a claim for workmen's compensation unless such an act is, in the opinion of the Secretary of HEW, clearly futile. HEW decided that payments for black lung were to be treated as workmen's compensation benefits for the purpose of social security disability benefit offset.

The Federal Government was to take claims for and finance this benefit until December 31, 1972, but claims filed in 1972 would be transferred to the State programs at the end of 1972, the so-called part C program. As of January 1, 1972, States with adequate workmen's compensation programs as judged by the Secretary of Labor would take over the cost of new claims. Coal mine operators would then be liable for the compensation payments if found responsible, by regulations promulgated by the Secretary of Labor. In those States where the workmen's compensation did not come up to the statutory standards for the amount of benefits and the various eligibility standards of Federal law and regulation and where no liable operator can be found, the Federal Government would still be responsible for payments. Claims filed on or before December 31, 1971 would be eligible for lifetime benefits from the Federal Government, all other claims payments will terminate on December 30, 1976.

When a point of order was raised in the House stating that many of the provisions in the Conference report were not in either bill, it was ruled that the changed provisions were germane and proper for consideration by the Conference since such points were not in agreement in both bills.

BLACK LUNG BENEFITS ACT OF 1972

In 1972 Congress felt that it was necessary to delay implementation of part C of the Black Lung Act until after December 31, 1973. It believed that this additional time was needed in order for the States to create workmen's compensation plans which would comply with Federal standards. The termination date of part C was also extended from 1976 to 1981. No payments under this part will be made after this time.

The conditions of eligibility were liberalized. The distinction between underground and aboveground mines for the purpose of disability payments was removed; thus, miners who worked in an aboveground mine can also collect benefits if found to be disabled by pneumoconiosis.

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[36] Ibid., sec. 411(c).

Congress was concerned over the high rate of denials of black lung claims. The Senate Labor and Public Welfare Committee report stated that the SSA definition of disability "is unrealistic when applied to coal miners, if it results in the denial of claims of miners who for medical reasons can no longer be expected to work in the mines and for whom there is no, too often, other realistic employment opportunity * * *." [37] The new more occupationally oriented definition of disability stipulates that a miner is to be considered disabled "when pneumoconiosis prevents him from engaging in gainful employment requiring the skills and abilities comparable to those of any employment in a mine or mines in which he previously engaged with some regularity and over a substantial period of time." (sec. 402(f)).

This amendment added another rebuttable presumption of disability to the two other such presumptions found in the Federal Coal Mine Health and Safety Act of 1969. The new presumption (sec. 411(c)(4)) states:

> if a miner was employed for fifteen years or more in one or more underground coal mines, and if there is a chest roentgenogram [X-ray] submitted in connection with such miner's, his widow's, his child's, his parent's, his brother's, his sister's or his dependent's claim under this title and it is interpreted as negative with respect to the requirements of paragraph (3) of this subsection, and if other evidence demonstrates the existence of a totally disabling respiratory or pulmonary impairment, then there shall be a rebuttable presumption that such miner is totally disabled due to pneumoconiosis, that his death was due to pneumoconiosis, or that at the time of his death he was totally disabled by pneumoconiosis. In the case of a living miner, a wife's affidavit may not be used by itself to establish the presumption.

A miner may not now be denied benefits solely on the basis of roentgenogram. (Sec. 413(b).) The Senate Report stated that:

> Testimony has further indicated that a negative X-ray is not proof positive of the absence of pneumoconiosis. Studies in addition to that of the Public Health Service confirm the existence of the disease by autopsy where a chest X-ray was negative, indicating an error of 25 percent in diagnosis.[38]

The 1972 Black Lung Act also liberalized benefits for dependents of disabled miners. Survivors of a miner who was totally disabled by pneumoconiosis at the time of his death may receive benefits even though the miner did not die from pneumoconiosis. Children of disabled miners are now eligible for benefits even if both parents are dead. Survivors coverage was also extended to dependent parents or to dependent brothers and sisters if no such parents existed, providing the miner was not survived by a wife or child.

Other changes in the law made section 206 of the Social Security Act, which limits attorney fees in disability cases, applicable to black lung benefits. A provision was added that stated that black lung benefits under part B were not to be considered a workmen's compensation payment for the purposes of the social security offset provision, thus, part B black lung recipients will receive the total amount of their social security disability benefits if they qualify. The new law also stipulates that no coal mine operator may discriminate against a miner employed by him who is suffering from pneumoconiosis.

A new section was added which provided for amendments of part B of this law to apply to part C where appropriate, except that no employment after June 30, 1971 would be considered as applying to the 15-year rebuttable presumption of disability included in this law.

The Secretary of HEW was instructed by this law to inform all black lung claimants who had been denied benefits that their claims were being reexamined in light of these new amendments.

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[37] S. Rept. No. 743, 92d Cong., p. 16.

[38] Ibid., p. 10.

SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED (PUBLIC LAW 92–603) (1972)

The supplemental security income for the aged, blind, and disabled was the one major provision in H.R. 1 dealing with "welfare reform". Effective January 1, 1974, it replaces (except in Puerto Rico, the Virgin Islands, and Guam) the present State programs of aid to the aged, blind, and disabled. This program provides from the Federal Government a guaranteed monthly income of $130 for an individual or $195 for a couple. The first $20 of social security or any other earned or unearned income (other than income based on need) will not cause any reduction in payments. In addition, $65 of earned income plus one-half of any remaining earnings will be disregarded. Also, any amount reasonably attributable to the earning of income would be disregarded for the blind and any income necessary for the fulfillment of a plan for achieving self-support will be disregarded for persons qualifying on the basis of blindness or disability. A grandfather clause provides that any person who was on the State APTD rolls in December 1973 and who continues to meet the State definition of blindness or disability in effect as of October 1972 will qualify for SSI benefits, except that no person who is medically determined to be a drug addict or an alcoholic will be eligible for SSI benefits unless such individual is undergoing appropriate treatment. Applicants who were not on the State rolls as of December 1973 will have to meet the definition of blindness or disability as stated in title II. Children under 18 with disabilities of comparable severity will be eligible.

Any aged, blind, or disabled person with resources less than $1,500 (or $2,250 for a couple) will be eligible. In determining his resources the value of a home (including land surrounding home), household goods, personal effects, an automobile, and property needed for self support will, if found to be reasonable, be excluded. Life insurance policies will not be counted if the face value of all policies is less than $1,500. (Current recipients under State programs with higher resource limits will be retained.) In determining the resources of a child under 21, the income and resources of the parents or spouse of a parent living in the same household as the child will be considered.

Any State wishing to supplement the benefits to the blind, aged, or disabled may do so. The law states that such payments be made to all persons who are eligible for federal supplemental payments, except where a State may require a period of residence as a condition of eligibility. The law provides no direct federal participation in the costs of State supplemental payments. However, HEW will pay administrative costs of federally administered State supplementation. Moreover, a savings clause is included under which the Federal Government will, if it administers the State payments, assume all of a State's cost of supplemental payments which exceed its calendar year 1972 share of the costs of aid to the aged, blind, and disabled. This savings clause will apply only to State supplementation needed to maintain the State's assistance levels in effect as of January 1972.

States are authorized to continue programs providing social services to the aged, blind, and disabled. There will be a 75-percent Federal matching for the services provided (90 percent for family planning) subject to the overall appropriation limitations established by the State and Local Fiscal Assistance Act.

The Secretary of HEW is to use the apparatus now used for social security disability determinations (sec. 221) for determinations of blindness and disability under this new law. In actuality, the State agencies' decisions are implemented immediately and a random sample is reviewed in the regional offices for quality control as well as decision accuracy. In SSA title II claims, a random sample is reviewed in BDI central and allowances are implemented from there while denials are implemented in the State agencies.

Because, by definition the claimants for SSI are in immediate need, it was felt that some kind of help should be available without the long wait that could accompany a decision, or the 5-month waiting period required for title II benefits. An emergency advance of $100 against future benefits may be made for a claimant who is presumptively eligible. Presumptive determinations of eligibility for 3 months may be made; after that time a final determination must be made. By regulation, a district Social Security Office may make a presumption of disability only if the claimant meets certain strict criteria of a medical nature. The State offices have more latitude in such decisions.

The Secretary of HEW is to provide for referral of disabled or blind SSI recipients to State rehabilitation agencies at least quarterly for reevaluation of disability and vocational rehabilitation services, except in such cases that he determines such action would be nonproductive. The recipient must accept such services if he is to remain eligible for payments. The Federal Government is to pay the State agency for such services received by the title XVI recipient.

PUBLIC LAW 93–66 (JULY 1973)

This law changed a number of provisions of the title XVI, supplemental security income for the aged, blind, and disabled including raising the payment level from $130 to $140 for an individual and from $195 to $210 for a couple, effective July 1974; and requiring that the supplementation of Federal payments by the States be made mandatory for recipients transferred from Federal-State programs. The States, in order to receive medicaid (title XIX) funds, must supplement the Federal recipients' benefits to bring them up to the recipients' December 1973 payment level. The Congress did not feel that a recipient should be penalized because the APTD program was federalized. Therefore, it enacted this provision to assure that no State APTD recipient would receive less than his State APTD payment under the Federal plan.

SOCIAL SECURITY AMENDMENTS OF 1973 (PUBLIC LAW 93–233) (DECEMBER 1973)

In 1973 the Congress became concerned over what it felt was an effort, at least in some States, to reduce their AFDC (aid to families with dependent children) cost at the expense of the Federal Government by moving AFDC mothers to APTD so they would be grandfathered in under SSI. The Senate Finance Committee report on legislation, aimed at curtailing this practice, stated:

> New York City is apparently hastily examining all AFDC caretaker relatives for disability in order to place the maximum number on aid to the disabled. An article appearing in the New York Times of September 24, 1973, indicated that 65 percent of the first 10,000 welfare mothers screened were found to have severe disabilities. New York City plans of test 250,000 welfare mothers in a ten-week period. This transfer of AFDC mothers to APTD would shift the cost from the Federal-State AFDC program to the Federal SSI program, with higher Federal and lower State costs.[39]

In order to prevent this transfer, Congress enacted a provision which would allow State APTD recipients to be grandfathered into SSI only if they were on the State rolls at least one month prior to July 1973 and were still on the rolls as of December 1973.

Because of the rise in the cost of living, it was decided to make the increases in SSI monthly payments of $140 for an individual and $210 for a couple, provided by Public Law 93–66 effective January 1974. In addition, SSI benefits would be increased to $146 for an individual and $219 for a couple, effective July 1, 1974.

PUBLIC LAW 93–256 (MARCH 1974)

This law extends from March to December 1974 or until a redetermination of disability is made, whichever occurs first, the authority of the Social Security Administration to pay benefits to these former APTD recipients whose eligibility for SSI benefits could not be determined within the prescribed time limits, under the provision authorizing payments for presumptive disability for 3 months. The Department of Health, Education, and Welfare estimated that by the end of March there would still be about 150,000 to 200,000 people whose eligibility would not yet have been decided. As the Committee on Ways and Means report states:

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[39] S. Rept. No. 529, 93d Cong., p. 25.

> Your committee has been advised by the Department of Health, Education, and Welfare that it is very likely that a substantial majority of the people subject to suspension of payments will ultimately be found to be eligible . . . Your committee is naturally concerned about the harsh and unjust effect of such a suspension.[40]

In addition, the Senate Finance Committee report stated that:

> While the Committee agrees that due care must be exercised so as to reach correct determinations it expects that those determinations will be made as promptly as possibie, consistent with that objective and that the Social Security Administration will assure that the disability determination units do not give these cases lowest priority simply because payments can be made on the basis of presumptive disability through December 1974. The committee emphasizes the importance of establishing stable precedents for disability determination which will have important consequences for the nature of the administration of the social security and SSI programs in future years.[41]

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[40] H. Rept. 871, 93d Cong., p. 2.

[41] S. Rept. No. 735, 93d Cong., p. 3.

B. STATISTICS AND PROGRAM INFORMATION

1. Organization of the Disability Program

A. Bureau of Disability Insurance

1. ORGANIZATIONAL STRUCTURE FOR THE ADMINISTRATION OF THE DISABILITY PROGRAM—BUREAUS PARTICIPATING WITH BUREAU OF DISABILITY INSURANCE

The Secretary of Health, Education, and Welfare has delegated to the Commissioner of Social Security the responsibility for administering the disability provisions of Title II and Title XVI of the Social Security Act. The Bureau of Disability Insurance (BDI) by redelegation from the Commissioner of Social Security has the administrative responsibility for the program's operation.

The following organizations participate with BDI in determining the rights of individuals to disability payments and in making benefit payments:

Bureau of District Office Operations through its district offices, which accept disability claims; transmit the claims to State agencies responsible for determining disability; adjudicate nonmedical factors of eligibility; and beginning in 1974, also authorize payment in certain categories of claims.

Bureau of Data Processing, which maintains earnings records; provides computer-generated computations of the monthly benefit (subject to adjustment if determination of the factors of eligibility changes); and provides computer services to BDI in the maintenance of disability benefit rolls and the maintenance of the disability case control system.

State agencies under contract with the Secretary to make determinations of disability for SSA, also responsible, beginning in 1974, for notifying claimants who are found not disabled and therefore not eligible for benefits.

Bureau of Hearings and Appeals, which is responsible for conducting hearings and rendering decisions when claimants, dissatisfied with a State agency or BDI determination, request a hearing under Section 221(d) of the Social Security Act.

2. ORGANIZATION OF THE BUREAU OF DISABILITY INSURANCE—TEXT AND CHARTS

The SSA-wide reorganization in 1965 created the Bureau of Disability Insurance to assume responsibilities formerly exercised by the Division of Disability Operations, and to have responsibility for coordinating with the Vocational Rehabilitation Administration with respect to paying the cost of rehabilitation services for disability beneficiaries from SSDI Trust Funds. At that time, responsibility for supervising the former Baltimore Payment Center, which handled the payment of disability claims, was also transferred from the former Division of Claims Control and organizationally integrated into the other Baltimore disability case processing operations The Bureau was also given responsibility for providing program policy guidance to the district offices on disability insurance matters and Bureau staff was assigned to HEW regional offices to perform program and management liaison functions with the State agency disability determination units and the district offices.

Since the 1965 reorganization, further structural evolution has occurred as administrative and operating functions have been realigned and organizational titles changed. The major organizational components at the present time follow.

Chief Medical Officer and Medical Consultant Staff

A Chief Medical Officer (for Title II), and the Medical Consultant Staff which he heads, are responsible for carrying out professional program responsibilities in the areas of medical policy development, program research, sample claims review, and operational consultation.

A Chief Medical Adviser (for SSI) has similar professional responsibilities in connection with the administration of the SSI program for the blind and disabled. He also provides professional direction to the newly appointed regional medical consultants and is responsible for maintaining close coordination with and between the regional medical consultants.

Assistant Bureau Director, Operations

The 1965 reorganization initially established a Division of Disability Operations consisting of a Reconsideration Branch, an Evaluation and Authorization Branch, and a Benefit Services Branch (performing the functions of the former Baltimore Payment Center). (Each of these branches soon became divisions). Two years later, a special Disability Inquiries Staff was established to answer claimant and third-party inquiries on pending claims. Still later this staff was given further responsibility for expediting the processing of claims from applicants in great need or suffering financial hardships.

In 1968 the functions of the Division of Benefit Services were distributed between two new divisions: the technical functions associated with processing awards to payment, adjusting monthly benefit amounts, and updating the benefit rolls were placed in the Division of Benefit Payments; the reorganized Division of Benefit Services has retained responsibility for mail, files, certain typing services, and case searching and control operations.

In 1970 the Division of Evaluation and Authorization was divided into two new divisions—the Division of Initial Claims and Division of Continuing Entitlement. The former became responsible for preparing certain initial non-State disability determinations, reviewing the initial disability determinations of the SA's, and authorizing benefits in allowed claims. The Division of Continuing Entitlement became responsible for evaluating a beneficiary's continuing entitlement to benefit payments.

Altogether, the functional responsibilities of the Divisions of the Office of the Assistant Bureau Director, Operations, encompass all disability claims processing functions performed at BDI Headquarters in Baltimore. In summary, they include the preparation of disability determinations in certain cases excluded from the States, the review of initial and reconsideration State agency disability determinations on a sample basis, the authorization and payment of entitled applicants, and continued surveillance and maintenance of the benefit rolls.

Assistant Bureau Director, Division of Field Operations

This Division is responsible for coordinating program services and providing program leadership and direction to the DI regional offices and the 54 participating SA's, and technical guidance on disability program policies and procedures to the DO's. This Division also has responsibility for coordinating SSA's relationships with RSA concerning the evaluation of disability applicants for rehabilitation potential and the oversight of expenditures of DI Trust Fund moneys for rehabilitation services provided by State VR agencies to SSDI beneficiaries.

Assistant Bureau Director, Division of Disability Policy and Procedures

This Division is responsible for promulgating all DI program and claims processing policies, procedures, systems and methods in district office, State agency and Baltimore claims processing operations. The Division also provides information services concerning SSA disability programs to the professional medical and paramedical communities.

Assistant Bureau Director, Administration

Comprising four divisions, the component is responsible for carrying out a broad range of administrative management staff activities including DI program analysis and reporting, operational research, budgeting, personnel administration, general and technical training, short and long-range planning, and general service functions. It also directs a program of internal management and quality assurance reviews.

Disability Insurance Regional Offices

Until the 1965 reorganization, the need for onsite liaison of the central DI organization with State agencies and the SSA field organization was met by a staff of Field Liaison Officers headquartered in Baltimore. Following the reorganization, BDI representatives were placed in the HEW regional offices, replacing the mobile staff that had been stationed in Baltimore. As the DI program has grown in size and complexity since then, and as more tasks and final adjudicative responsibility have been transferred to SA's and DO's, the DI Regional Representatives and their staff have been increasingly useful.

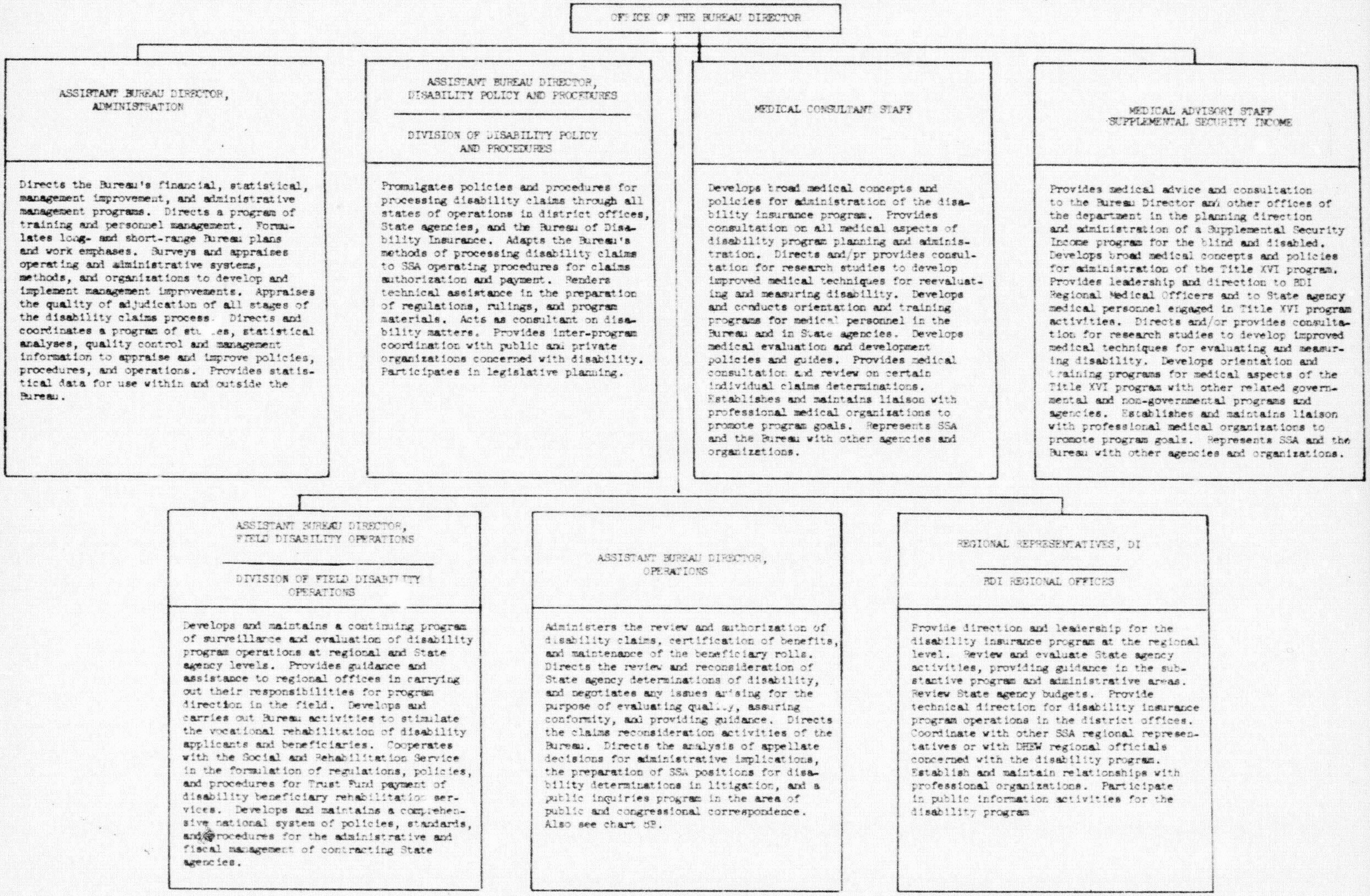
Until 1973, the structure of the Regional Representative's staff was very simple, consisting of several Assistant Regional Representatives, sometimes an Associate Regional Representative, one or more staff assistants, and supporting clerical staff.

Early in the planning for administration of the SSI program, the decision was reached to minimize the flow of SSI disability and blindness claims to BDI's Baltimore operations by providing for sampling review of the SA disability determinations in these claims to be conducted under the supervision of the DI Regional Representative. At the same time, in recognition of the increasing load of staff work required of the DI regional personnel, a more structured organization was approved by the Secretary. (Organizational diagrams depicting the current arrangements are provided at p. 128.)

The sample review of SSI disability and blindness determinations will be performed in the Claims Review Sections of the DIRO. The SSI claims folders will be maintained in RSI Program Centers (PC's). In the six regions where the PC's are located, the DIRO also includes a Technical Assistance Section colocated in the PC to provide technical advice to PC personnel on Title XVI cases that involve disability issues.

ORGANIZATION CHARTS

A. Bureau of Disability Insurance



OFFICE OF THE BUREAU DIRECTOR

ASSISTANT BUREAU DIRECTOR, ADMINISTRATION

Directs the Bureau's financial, statistical, management improvement, and administrative management programs. Directs a program of training and personnel management. Formulates long- and short-range Bureau plans and work emphases. Surveys and appraises operating and administrative systems, methods, and organizations to develop and implement management improvements. Appraises the quality of adjudication of all stages of the disability claims process. Directs and coordinates a program of studies, statistical analyses, quality control and management information to appraise and improve policies, procedures, and operations. Provides statistical data for use within and outside the Bureau.

ASSISTANT BUREAU DIRECTOR, DISABILITY POLICY AND PROCEDURES

DIVISION OF DISABILITY POLICY AND PROCEDURES

Promulgates policies and procedures for processing disability claims through all states of operations in district offices, State agencies, and the Bureau of Disability Insurance. Adapts the Bureau's methods of processing disability claims to SSA operating procedures for claims authorization and payment. Renders technical assistance in the preparation of regulations, rulings, and program materials. Acts as consultant on disability matters. Provides inter-program coordination with public and private organizations concerned with disability. Participates in legislative planning.

MEDICAL CONSULTANT STAFF

Develops broad medical concepts and policies for administration of the disability insurance program. Provides consultation on all medical aspects of disability program planning and administration. Directs and/pr provides consultation for research studies to develop improved medical techniques for reevaluating and measuring disability. Develops and conducts orientation and training programs for medical personnel in the Bureau and in State agencies. Develops medical evaluation and development policies and guides. Provides medical consultation and review on certain individual claims determinations. Establishes and maintains liaison with professional medical organizations to promote program goals. Represents SSA and the Bureau with other agencies and organizations.

MEDICAL ADVISORY STAFF SUPPLEMENTAL SECURITY INCOME

Provides medical advice and consultation to the Bureau Director and other offices of the department in the planning direction and administration of a Supplemental Security Income program for the blind and disabled. Develops broad medical concepts and policies for administration of the Title XVI program. Provides leadership and direction to BDI Regional Medical Officers and to State agency medical personnel engaged in Title XVI program activities. Directs and/or provides consultation for research studies to develop improved medical techniques for evaluating and measuring disability. Develops orientation and training programs for medical aspects of the Title XVI program with other related governmental and non-governmental programs and agencies. Establishes and maintains liaison with professional medical organizations to promote program goals. Represents SSA and the Bureau with other agencies and organizations.

ASSISTANT BUREAU DIRECTOR, FIELD DISABILITY OPERATIONS

DIVISION OF FIELD DISABILITY OPERATIONS

Develops and maintains a continuing program of surveillance and evaluation of disability program operations at regional and State agency levels. Provides guidance and assistance to regional offices in carrying out their responsibilities for program direction in the field. Develops and carries out Bureau activities to stimulate the vocational rehabilitation of disability applicants and beneficiaries. Cooperates with the Social and Rehabilitation Service in the formulation of regulations, policies, and procedures for Trust Fund payment of disability beneficiary rehabilitation services. Develops and maintains a comprehensive national system of policies, standards, and procedures for the administrative and fiscal management of contracting State agencies.

ASSISTANT BUREAU DIRECTOR, OPERATIONS

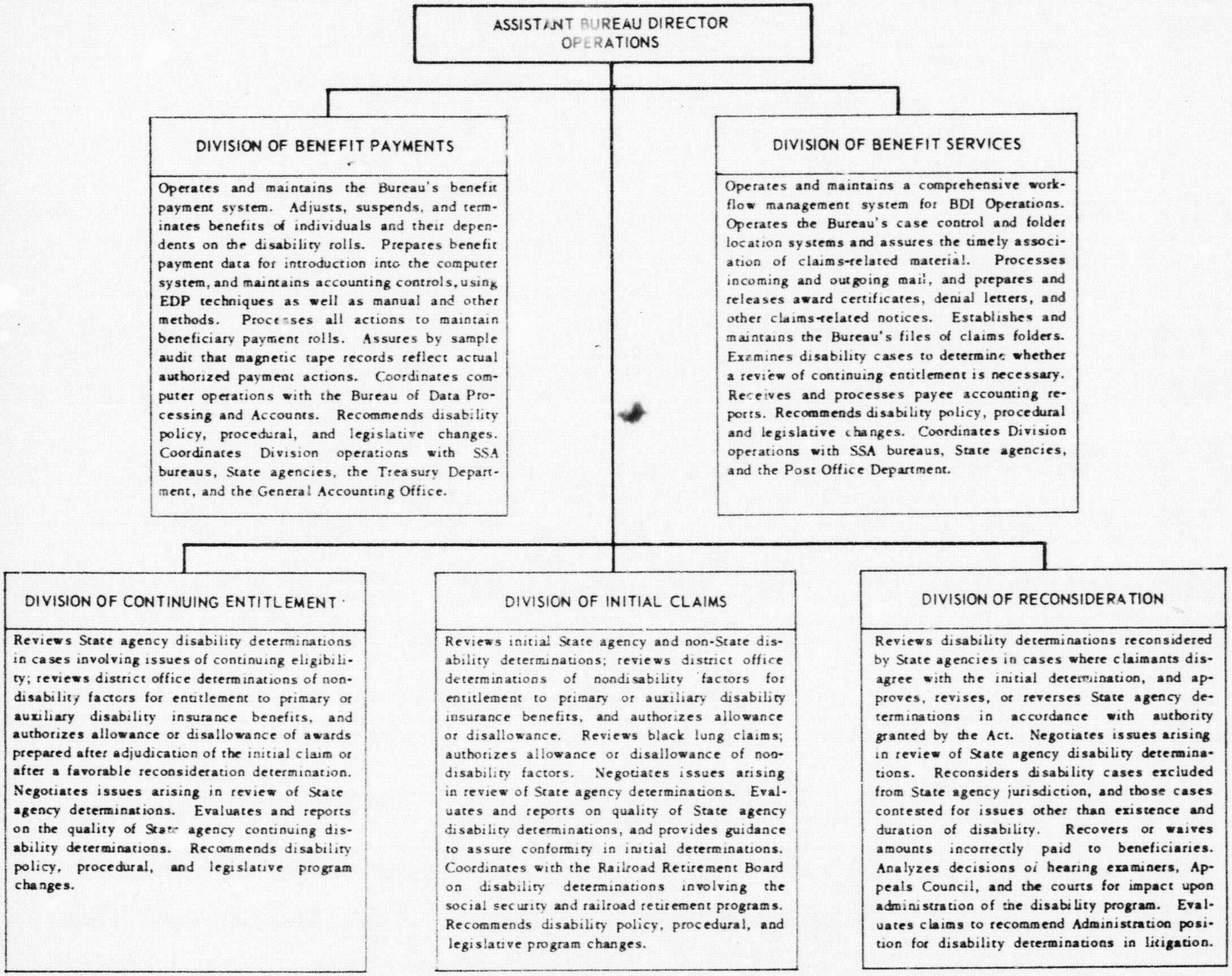
Administers the review and authorization of disability claims, certification of benefits, and maintenance of the beneficiary rolls. Directs the review and reconsideration of State agency determinations of disability, and negotiates any issues arising for the purpose of evaluating quality, assuring conformity, and providing guidance. Directs the claims reconsideration activities of the Bureau. Directs the analysis of appellate decisions for administrative implications, the preparation of SSA positions for disability determinations in litigation, and a public inquiries program in the area of public and congressional correspondence. Also see chart 5B.

REGIONAL REPRESENTATIVES, DI

BDI REGIONAL OFFICES

Provide direction and leadership for the disability insurance program at the regional level. Review and evaluate State agency activities, providing guidance in the substantive program and administrative areas. Review State agency budgets. Provide technical direction for disability insurance program operations in the district offices. Coordinate with other SSA regional representatives or with DHEW regional officials concerned with the disability program. Establish and maintain relationships with professional organizations. Participate in public information activities for the disability program

B. Assistant Bureau Director, Operations



ASSISTANT BUREAU DIRECTOR OPERATIONS

DIVISION OF BENEFIT PAYMENTS

Operates and maintains the Bureau's benefit payment system. Adjusts, suspends, and terminates benefits of individuals and their dependents on the disability rolls. Prepares benefit payment data for introduction into the computer system, and maintains accounting controls, using EDP techniques as well as manual and other methods. Processes all actions to maintain beneficiary payment rolls. Assures by sample audit that magnetic tape records reflect actual authorized payment actions. Coordinates computer operations with the Bureau of Data Processing and Accounts. Recommends disability policy, procedural, and legislative changes. Coordinates Division operations with SSA bureaus, State agencies, the Treasury Department, and the General Accounting Office.

DIVISION OF BENEFIT SERVICES

Operates and maintains a comprehensive workflow management system for BDI Operations. Operates the Bureau's case control and folder location systems and assures the timely association of claims-related material. Processes incoming and outgoing mail, and prepares and releases award certificates, denial letters, and other claims-related notices. Establishes and maintains the Bureau's files of claims folders. Examines disability cases to determine whether a review of continuing entitlement is necessary. Receives and processes payee accounting reports. Recommends disability policy, procedural and legislative changes. Coordinates Division operations with SSA bureaus, State agencies, and the Post Office Department.

DIVISION OF CONTINUING ENTITLEMENT

Reviews State agency disability determinations in cases involving issues of continuing eligibility; reviews district office determinations of nondisability factors for entitlement to primary or auxiliary disability insurance benefits, and authorizes allowance or disallowance of awards prepared after adjudication of the initial claim or after a favorable reconsideration determination. Negotiates issues arising in review of State agency determinations. Evaluates and reports on the quality of State agency continuing disability determinations. Recommends disability policy, procedural, and legislative program changes.

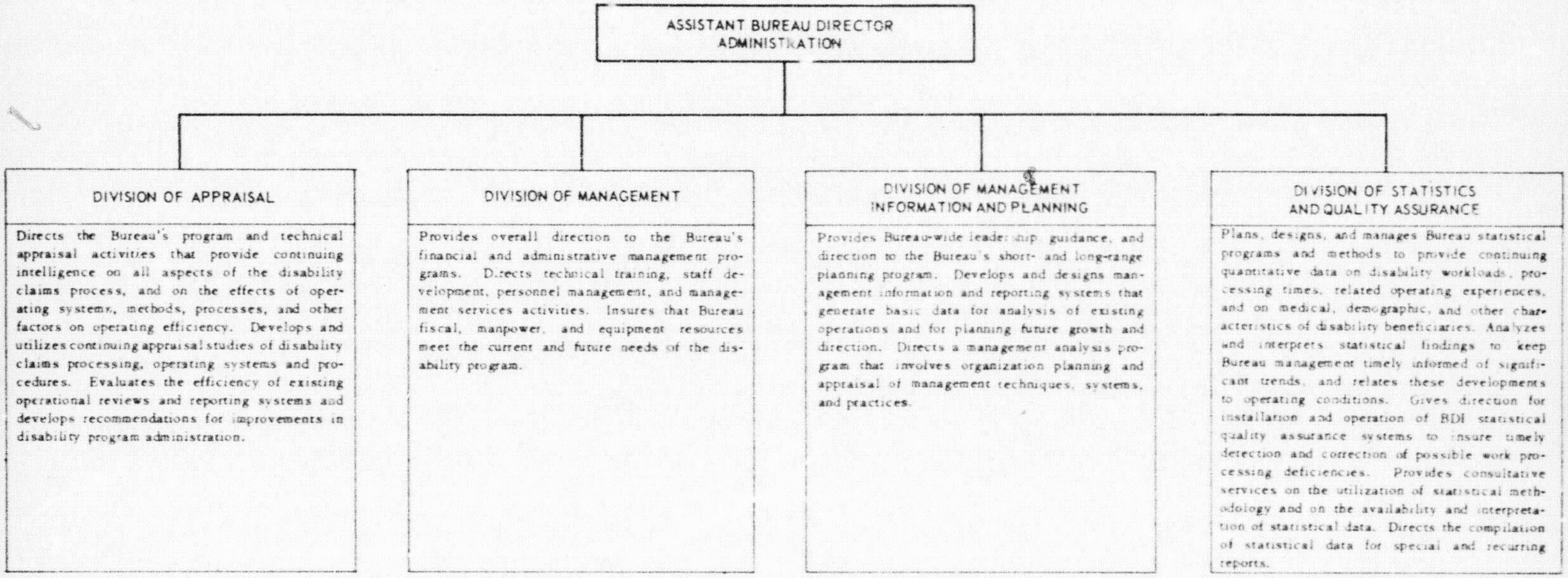
DIVISION OF INITIAL CLAIMS

Reviews initial State agency and non-State disability determinations; reviews district office determinations of nondisability factors for entitlement to primary or auxiliary disability insurance benefits, and authorizes allowance or disallowance. Reviews black lung claims; authorizes allowance or disallowance of nondisability factors. Negotiates issues arising in review of State agency determinations. Evaluates and reports on quality of State agency disability determinations, and provides guidance to assure conformity in initial determinations. Coordinates with the Railroad Retirement Board on disability determinations involving the social security and railroad retirement programs. Recommends disability policy, procedural, and legislative program changes.

DIVISION OF RECONSIDERATION

Reviews disability determinations reconsidered by State agencies in cases where claimants disagree with the initial determination, and approves, revises, or reverses State agency determinations in accordance with authority granted by the Act. Negotiates issues arising in review of State agency disability determinations. Reconsiders disability cases excluded from State agency jurisdiction, and those cases contested for issues other than existence and duration of disability. Recovers or waives amounts incorrectly paid to beneficiaries. Analyzes decisions of hearing examiners, Appeals Council, and the courts for impact upon administration of the disability program. Evaluates claims to recommend Administration position for disability determinations in litigation.

C. Assistant Bureau Director. Administration



ASSISTANT BUREAU DIRECTOR
ADMINISTRATION

DIVISION OF APPRAISAL

Directs the Bureau's program and technical appraisal activities that provide continuing intelligence on all aspects of the disability claims process, and on the effects of operating systems, methods, processes, and other factors on operating efficiency. Develops and utilizes continuing appraisal studies of disability claims processing, operating systems and procedures. Evaluates the efficiency of existing operational reviews and reporting systems and develops recommendations for improvements in disability program administration.

DIVISION OF MANAGEMENT

Provides overall direction to the Bureau's financial and administrative management programs. Directs technical training, staff development, personnel management, and management services activities. Insures that Bureau fiscal, manpower, and equipment resources meet the current and future needs of the disability program.

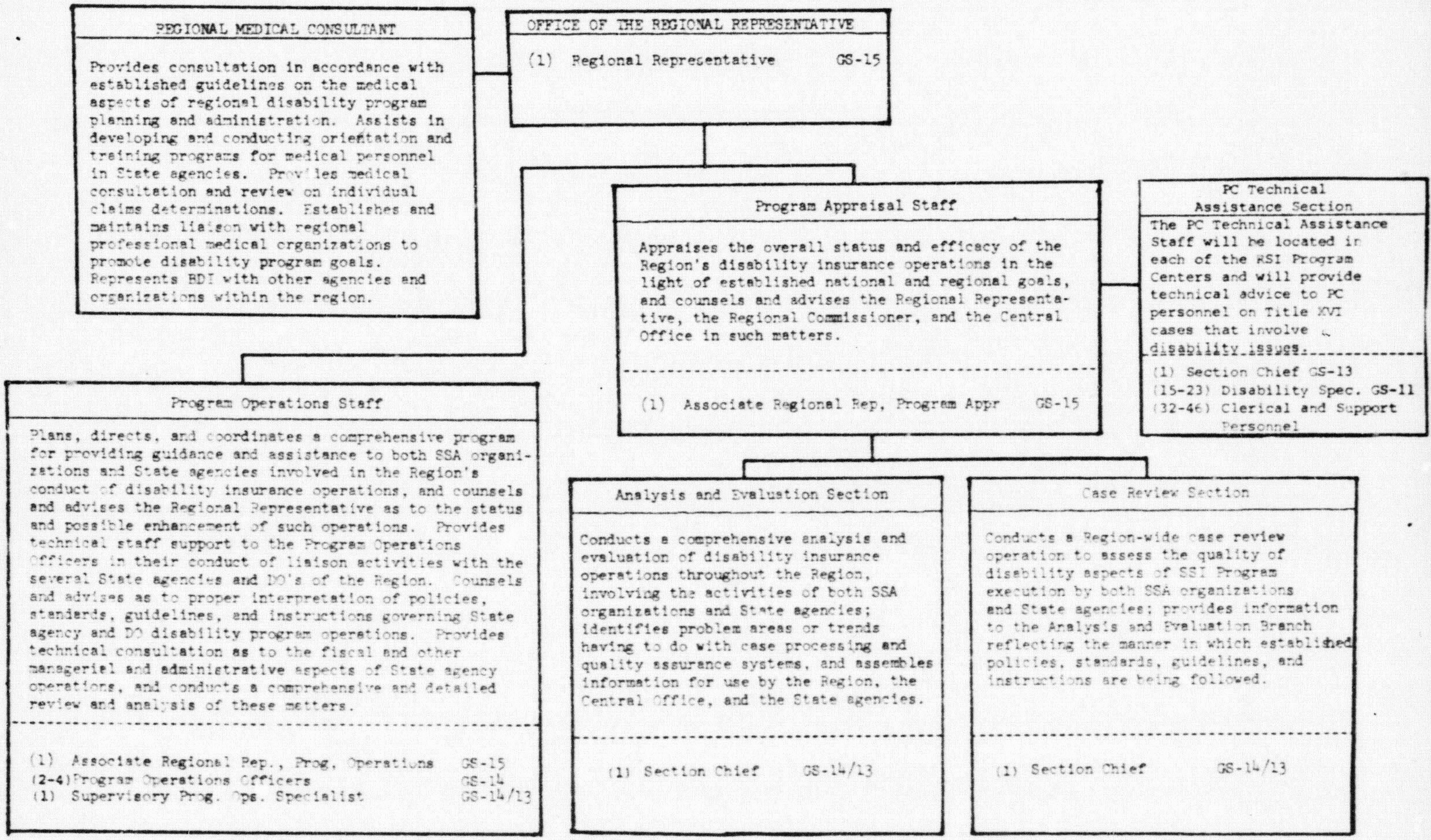
DIVISION OF MANAGEMENT INFORMATION AND PLANNING

Provides Bureau-wide leadership, guidance, and direction to the Bureau's short- and long-range planning program. Develops and designs management information and reporting systems that generate basic data for analysis of existing operations and for planning future growth and direction. Directs a management analysis program that involves organization planning and appraisal of management techniques, systems, and practices.

DIVISION OF STATISTICS AND QUALITY ASSURANCE

Plans, designs, and manages Bureau statistical programs and methods to provide continuing quantitative data on disability workloads, processing times, related operating experiences, and on medical, demographic, and other characteristics of disability beneficiaries. Analyzes and interprets statistical findings to keep Bureau management timely informed of significant trends, and relates these developments to operating conditions. Gives direction for installation and operation of BDI statistical quality assurance systems to insure timely detection and correction of possible work processing deficiencies. Provides consultative services on the utilization of statistical methodology and on the availability and interpretation of statistical data. Directs the compilation of statistical data for special and recurring reports.

D. Proposed Disability Insurance Regional Office



OFFICE OF THE REGIONAL REPRESENTATIVE

(1) Regional Representative GS-15

REGIONAL MEDICAL CONSULTANT

Provides consultation in accordance with established guidelines on the medical aspects of regional disability program planning and administration. Assists in developing and conducting orientation and training programs for medical personnel in State agencies. Provides medical consultation and review on individual claims determinations. Establishes and maintains liaison with regional professional medical organizations to promote disability program goals. Represents BDI with other agencies and organizations within the region.

Program Appraisal Staff

Appraises the overall status and efficacy of the Region's disability insurance operations in the light of established national and regional goals, and counsels and advises the Regional Representative, the Regional Commissioner, and the Central Office in such matters.

(1) Associate Regional Rep, Program Appr GS-15

PC Technical Assistance Section

The PC Technical Assistance Staff will be located in each of the RSI Program Centers and will provide technical advice to PC personnel on Title XVI cases that involve disability issues.

(1) Section Chief GS-13
(15-23) Disability Spec. GS-11
(32-46) Clerical and Support Personnel

Program Operations Staff

Plans, directs, and coordinates a comprehensive program for providing guidance and assistance to both SSA organizations and State agencies involved in the Region's conduct of disability insurance operations, and counsels and advises the Regional Representative as to the status and possible enhancement of such operations. Provides technical staff support to the Program Operations Officers in their conduct of liaison activities with the several State agencies and DO's of the Region. Counsels and advises as to proper interpretation of policies, standards, guidelines, and instructions governing State agency and DO disability program operations. Provides technical consultation as to the fiscal and other managerial and administrative aspects of State agency operations, and conducts a comprehensive and detailed review and analysis of these matters.

(1) Associate Regional Rep., Prog. Operations GS-15
(2-4) Program Operations Officers GS-14
(1) Supervisory Prog. Ops. Specialist GS-14/13

Analysis and Evaluation Section

Conducts a comprehensive analysis and evaluation of disability insurance operations throughout the Region, involving the activities of both SSA organizations and State agencies; identifies problem areas or trends having to do with case processing and quality assurance systems, and assembles information for use by the Region, the Central Office, and the State agencies.

(1) Section Chief GS-14/13

Case Review Section

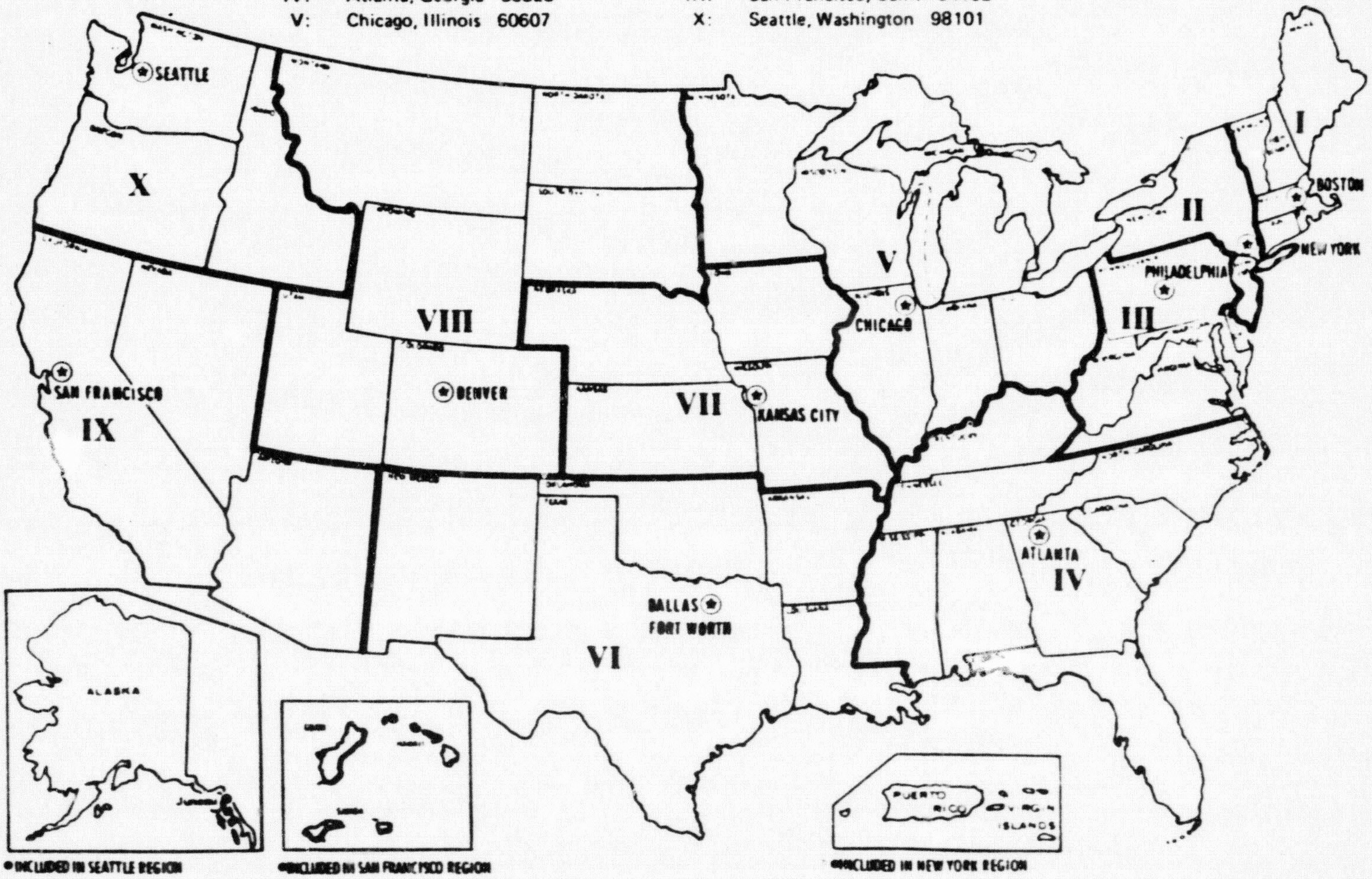
Conducts a Region-wide case review operation to assess the quality of disability aspects of SSI Program execution by both SSA organizations and State agencies; provides information to the Analysis and Evaluation Branch reflecting the manner in which established policies, standards, guidelines, and instructions are being followed.

(1) Section Chief GS-14/13

E. Social Security Administration – Regional Boundaries

Region I: Boston, Mass. 02203
II: New York, N.Y. 10007
III: Philadelphia, Pa. 19108
IV: Atlanta, Georgia 30323
V: Chicago, Illinois 60607

Region VI: Dallas, Texas 75202
VII: Kansas City, Mo. 64106
VIII: Denver, Colorado 80202
IX: San Francisco, Calif. 94102
X: Seattle, Washington 98101


SEATTLE
X
VIII
DENVER
SAN FRANCISCO
IX
VII
KANSAS CITY
V
CHICAGO
II
I
BOSTON
NEW YORK
PHILADELPHIA
III
ATLANTA
IV
DALLAS
FORT WORTH
VI
ALASKA
Juneau
PUERTO RICO
VIRGIN ISLANDS
INCLUDED IN SEATTLE REGION
INCLUDED IN SAN FRANCISCO REGION
INCLUDED IN NEW YORK REGION

Also included in San Francisco Region: Wake Island and Trust Territory of Pacific Islands.

3. BUREAU OF DISABILITY INSURANCE BUDGET—SOCIAL SECURITY ACT AND BLACK LUNG

TABLE 2.—*Bureau of Disability Insurance operating budget for fiscal year 1974, as reprogramed November 1973*

[In thousands of dollars]

	Total allocations	For State agency operations	For BDI program
Social security (title II)	244, 040	94, 454	78, 595
Supplemental security income (title XVI)		70, 991	
Black lung claims	22, 502	9, 933	12, 569
Total	266, 542	175, 378	91, 164

4. STAFFING OF BUREAU OF DISABILITY INSURANCE

TABLE 3.—*Full-time permanent positions on duty and budgeted, fiscal year 1974*

	Incumbents on Feb. 16, 1974	End of fiscal year 1974, budgeted
Total full-time permanent positions	6, 080	6, 104
Headquarters, total	5, 670	5, 347
Office of Bureau Director	19	19
Division of Field Disability Operations	75	75
Division of Disability Policy and Procedures	191	180
Medical Consultant Staff	60	60
Office of Assistant Bureau Director (Administration)[1]	82	82
Division of Management	92	111
Division of Management Information and Planning	32	36
Division of Appraisal	34	43
Division of Statistics and Quality Assurance	70	80
Office of Assistant Bureau Director Operations	20	20
Disability Inquiries Staff	268	253
Division of Initial Claims	714	645
Division of Reconsideration	715	648
Division of Continuing Entitlement	674	671
Division of Benefit Payments	1, 282	1, 282
Division of Benefit Services	1, 342	1, 142
Total, Regions I–X	410	757
Region I, Boston	25	51
Claims Review Section	(10)	(30)
Region II, New York	40	83
Claims Review Section	(16)	(39)
Technical Assistance Section	(2)	(18)
Region III, Philadelphia	62	109
Claims Review Section	(34)	(47)
Technical Assistance Section	(9)	(13)
Region IV, Atlanta	71	116
Claims Review Section	(33)	(64)
Technical Assistance Section	(8)	(13)
Region V, Chicago	73	121
Claims Review Section	(34)	(70)
Technical Assistance Section	(14)	(17)
Region VI, Dallas	40	66
Claims Review Section	(20)	(42)
Region VII, Kansas City	27	64
Claims Review Section	(4)	(24)
Technical Assistance Section	(9)	(17)
Region VIII, Denver	13	38
Claims Review Section	(5)	(20)
Region IX, San Francisco	34	72
Claims Review Section	(17)	(37)
Technical Assistance Section	(5)	(13)
Region X, Seattle	24	37
Claims Review Section	(6)	(20)
Total part-time or contract medical consultants	156	
Headquarters	141	
Regions	15	

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[1] Includes BDI intern positions.

5. ROLES OF DISTRICT OFFICES, STATE AGENCY, AND BALTIMORE CENTRAL OFFICE IN INITIAL DETERMINATION OF DISABILITY; AND MAN YEARS OF EMPLOYMENT OF STAFF INVOLVED IN EACH AGENCY

Claims Intake and Initial Development

Social Security—Title II claims

Disability claims are filed by a claimant or his representative in one of approximately 1,200 SSA district offices (DO) or subbranches. The district office performs an intake interview, places the claim under control of the computerized claims control system, and marshals the claimant's OASDI earnings data to determine technical eligibility. Until 1971 the district office also obtained all relevant medical evidence of disability and job fitness. In 1971 this responsibility was transferred from the district offices to the State agencies (SA). Now, the district office (DO) obtains the names of the physicians, hospitals, or clinics that have treated the claimant; and while the DO is completing the nonmedical file, the State agency gathers the medical data from the medical sources. The procedure has been successful in expediting the gathering of complete medical information, reducing frequent physician recontacts, and making better use of evidence in the files of treating physicians with less frequent resort to purchased examinations.

The Social Security, Administration (SSA) has recently implemented further modifications of the order of initial development. To minimize the amount of work involved in obtaining evidence concerning the nonmedical factors of eligibility, DO's now defer any special efforts needed to obtain this evidence, except in critical cases, until the State agency determines that the disability claimant is in fact disabled. (This is part of a larger change which has placed in the district offices DI claims authorization responsibility for certain claims.) Another modification that has just been instituted transfers from the SA's to the DO's responsibility for preparing disability determinations where the sole issue is whether an applicant or beneficiary's work activity demonstrates an ability to engage in substantial gainful activity.

Approximately 18 to 23 percent of the claims filed in the district office in Fiscal Year's 1970–73 failed at the outset because the claimant did not have "insured status." When the DO claims representative recognizes the probability that the claimant is not insured, he waits to confirm this fact from the earnings record. Upon confirmation, the DO forwards the claimant's file to SSA headquarters where a formal notification of denial is prepared and sent to the claimant. (A proposal that the DO notify the claimant of the denial before the claim is forwarded to SSA headquarters will shortly be implemented.)

Supplemental Security Income—Title XVI claims

Initial development in Title XVI disability and blindness claims differs from Title II disability claims processing in the following respects:

(1) Since insured status is not a factor in Title XVI claims, no earnings record is required.

(2) The DO evaluates the claimant's income and resources and determines that he meets the nonmedical factors of eligibility before referring the claim to the State agency for a determination of disability.

(3) If the claimant is already receiving a Title II disability benefit, no additional disability determination in the Title XVI claim and no referral to the State agency are needed.

Initial Determination of Disability

The disability determination unit (DDU) in the claimant's home State receives from the district office the claimant's application, any medical records he has provided, his list of medical evidence sources, and other information obtained during the intake interview. (The DDU is a component, usually, of the State vocational rehabilitation agency, but in a few States it is located in the State welfare agency, and in a few it is an independent State agency.)

After the DDU has obtained the required medical evidence from the claimant's sources, or from special examinations, a two-man team consisting of a physician and a lay disability evaluator makes the disability determination and prepares a short written decision which becomes part of the basic file, If the DDU denies the applicant's claim, it notifies the applicant.

The disability determination in a small group of initial claims is made by evaluators in BDI's central office rather than in the DDU. These include:

(1) Claims from persons residing in U.S. possessions (Virgin Islands, American Samoa).

(2) Claims filed by or on behalf of career railroad workers.

(3) Claims of individuals who are entitled to a survivor's RR annuity as a disabled dependent of a deceased career RR worker.

(4) Claims for hospital insurance and supplemental medical insurance coverage from individuals who have chronic renal disease and require hemodialysis or renal transplantation.

Quality Review and Appraisal

For many years the Bureau of Disability Insurance attempted to assure the correctness of the final decision by reviewing every DDU determination. In 1970 determinations in a few low-risk categories were exempted from BDI review, aside from a small sample of cases reviewed for quality assurance purposes. In 1972 review was reduced to a 5 percent sampling of State agency determinations. The entire 5 percent sample is first reviewed by the Medical Consultant Staff (MCS). If questions on nonmedical issues arise the MCS refers the claim to DIC. All sample cases are then reviewed by the lay disability examiner staff for both substantive and technical adjudicative deficiencies. These reviews are designed to insure the continuing efficacy of the medical and nonmedical guidelines and their application. They are not only more intensive than formerly, but include the compilation of data for all sample cases. The reduced number of disability determinations now reviewed in BDI necessarily yields fewer occasions to return a State agency determination for further development or consideration, although the more intensive review results in a proportionately larger return of reviewed cases. (By statute, a recommended approval of a disability claim can be rejected outright by BDI, or the date of onset of disability found to be later. On the other hand, a State agency's denial of a claim cannot be reversed directly or an earlier onset date established, although the claim may be remanded with a recommendation that the State agency change its decision.) The sampling practice makes the State agency decision the effective initial determination for most claims.

Categories of claims still reviewed on a 100 percent basis include:

(1) "Reopenings" (claims in which the applicant has submitted evidence that was not considered before an earlier decision to deny was rendered and which is likely to permit a finding of disability).

(2) "Subsequent application" cases where there exists a potential for "reopening".

(3) Claims in which the claimant's capability is at issue.

Supplemental Security Income—Title XVI Claims

Review of Title XVI disability and blindness claims differs from Social Security Title II disability claims review in the following respects:

(1) The 5-percent quality assurance review of SSI (and concurrent SSI–DI) claims is performed by BDI claims examiners in the regional offices—in the newly established Case Review Sections (CRS) rather than at BDI headquarters.

(2) All nonsample claims folders (and the folders of sample cases upon completion of all quality assurance reviews) are returned to the DO's for retention through the appeals period rather than to BDI CO. At the expiration of the appeals period, SSI disability claims folders are forwarded for filing to either the Payment Center or BDI depending on whether the applicant has also filed for SSDI benefits or not.

(3) Under SSI payment processing system procedures, the SA's "key-in" the basic disability decision data directly to the supplemental security record and SSI payment tapes via the Advanced Record System equipment installed recently in all DDU's. Currently the SA's play no role in processing payment actions in regular Social Security (Title II) claims.

(4) Quality assurance review of SSI claims will be performed after a determination has been made and notice has been released to the applicant.

(5) BDI is not prohibited by Title XVI from revising a State agency decision to make it more favorable to the claimant. Therefore when CRS review of a claim reveals that disability may have started earlier than the date established by the State agencies, the CRS may revise the date established by the SA to a more favorable date without returning the case to the SA. An erroneous denial may also be reversed.

Reconsideration

If the first decision in an initial claim is one of denial, the claimant must request a reconsideration within 6 months or the denial becomes final. A claimant's request initiates the reconsideration process, and the State agency determination procedure is repeated.

The first step in the reconsideration process is the updating of the file by the district office. At this point the claimant may have an interview and submit additional medical evidence. Often, he will choose a new physician or consult specialists and thus present a stronger case than at the initial determination stage. The second step is review of the file by the State agency, the file is again forwarded to BDI in Baltimore. (It is planned that SSI reconsideration will be forwarded to the Regional Office Case Review Section.) Here a 10 percent sample of SA decisions is reviewed for quality assurance purposes. As in the case of the initial Title II claims, BDI may reject a State agency decision to allow after reconsidering a formerly denied claim, but can only send the claim back to the agency with a recommendation for an allowance if, upon reconsideration, the agency has upheld an initial determination of denial.

Staffing

District Offices (DO's)

In fiscal year 1973, 3,501 man-years were expended on initial DI claims in the DO's. In fiscal year 1974, 4,668 man-years were budgeted for initial Title II disability claims in the district offices and another 3,400 man-years was budgeted for Title XVI disability claims. In fiscal year 1975 it is estimated the district offices will require 4,222 man-years to process Title II and 3,000 man-years to process Title XVI disability claims.

State Agencies (SA's)

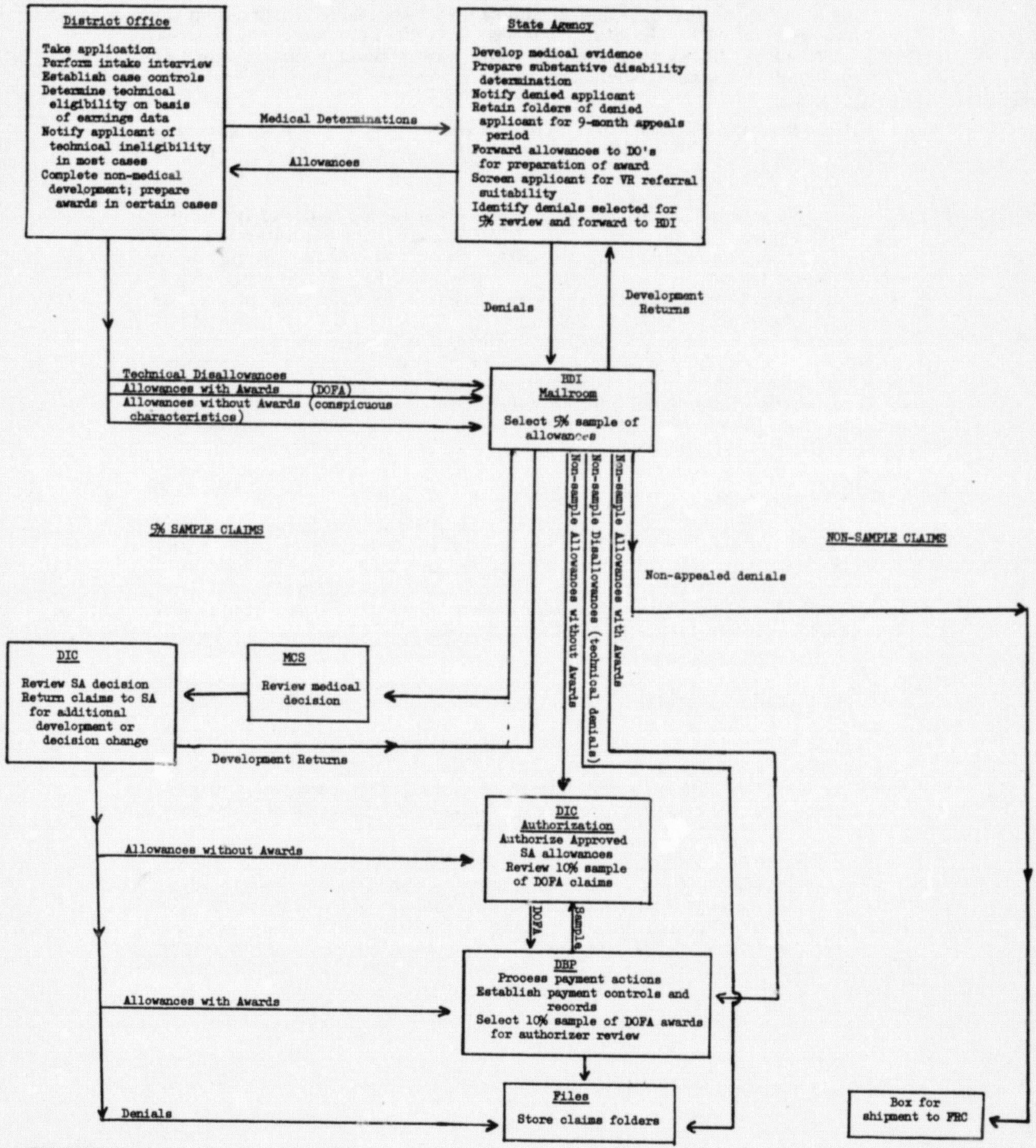
In fiscal year 1973, the SA's required 2,885 man-years to process initial Title II disability workloads. In fiscal year 1974 the SA's have been budgeted 3,545 man-years for processing Title II and 2,607 man-years for processing SSI (Title XVI) disability claims. The latter figure includes the manpower required for the States to perform the additional functions of keying SSI disability decisions data into SSA headquarter computer operations and preparing responses to certain types of inquiries about SSI decisions or processing status.

Bureau of Disability Insurance Central Office—(BDI CO)

In fiscal year 1973, 671 man-years were expended in processing initial Title II disability claims in BDI. The corresponding figures for fiscal years 1974 and 1975 are 681 and 664 man-years, respectively. It is also estimated the Bureau will expend 117 RO and 77 CO man-years in fiscal year 1974 in processing initial SSI (Title XVI) disability claims. The corresponding figures for fiscal year 1975 are 127, and 79 man-years, respectively.

6. CLAIMS FLOW CHARTS–INITIAL DETERMINATION

Social Security (Title II Claims) Initial Determination

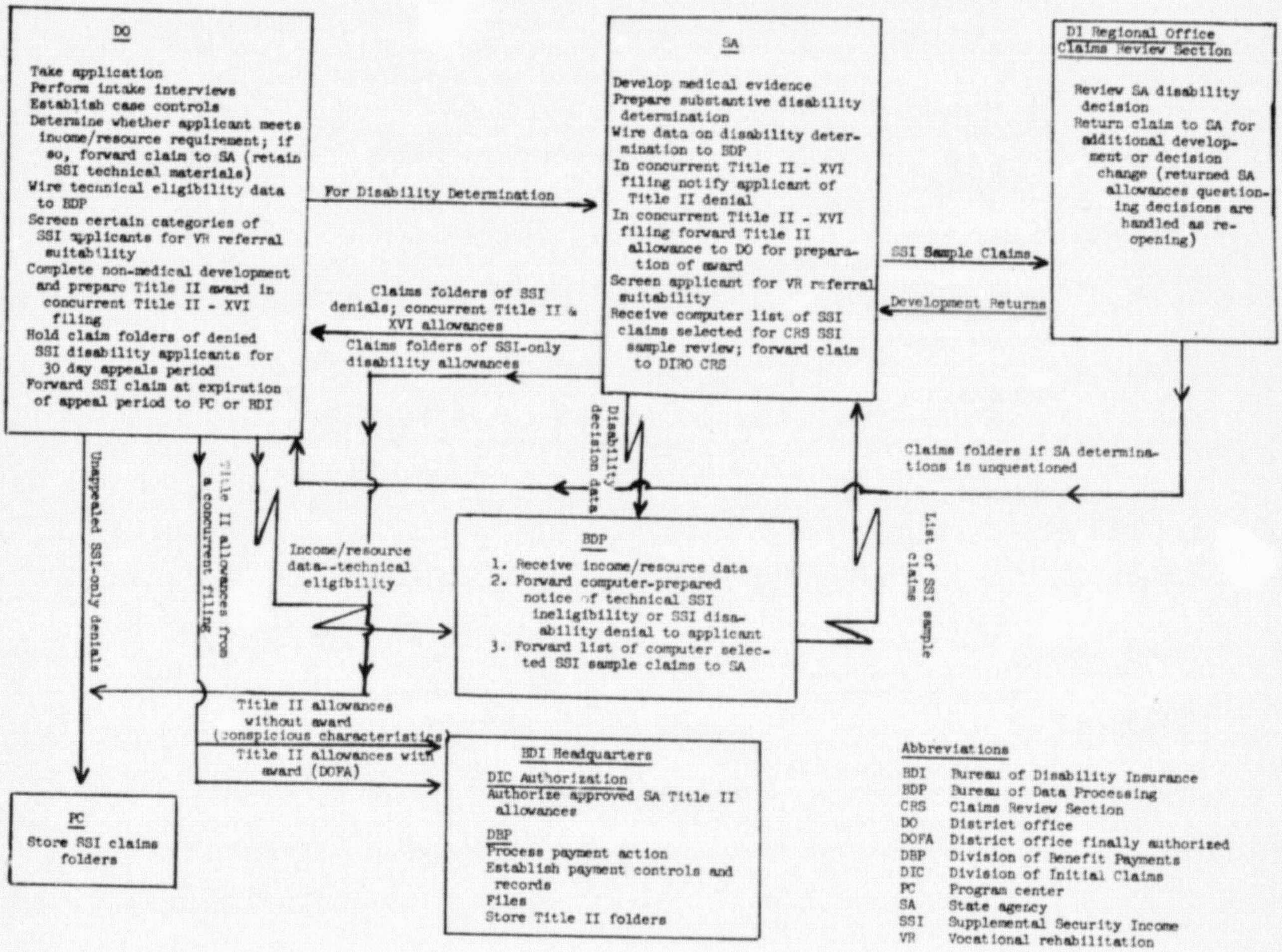

District Office
Take application
Perform intake interview
Establish case controls
Determine technical eligibility on basis of earnings data
Notify applicant of technical ineligibility in most cases
Complete non-medical development; prepare awards in certain cases
Medical Determinations
Allowances
State Agency
Develop medical evidence
Prepare substantive disability determination
Notify denied applicant
Retain folders of denied applicant for 9-month appeals period
Forward allowances to DO's for preparation of award
Screen applicant for VR referral suitability
Identify denials selected for 5% review and forward to BDI
Denials
Development Returns
Technical Disallowances
Allowances with Awards (DOFA)
Allowances without Awards (conspicuous characteristics)
BDI
Mailroom
Select 5% sample of allowances
5% SAMPLE CLAIMS
NON-SAMPLE CLAIMS
Non-sample Allowances without Awards
Non-sample Disallowances (technical denials)
Non-sample Allowances with Awards
Non-appealed denials
DIC
Review SA decision
Return claims to SA for additional development or decision change
MCS
Review medical decision
Development Returns
Allowances without Awards
DIC
Authorization
Authorize Approved SA allowances
Review 10% sample of DOFA claims
DOFA
Sample
Allowances with Awards
DBP
Process payment actions
Establish payment controls and records
Select 10% sample of DOFA awards for authorizer review
Denials
Files
Store claims folders
Box for shipment to FRC

Abbreviations

BDI	Bureau of Disability Insurance
DO	District office
DOFA	District office finally authorized
DBP	Division of Benefit Payments
DIC	Division of Initial Claims
FRC	Federal Records Center
MCS	Medical Consultant Staff
SA	State agency
VR	Vocational rehabilitation

03/25/74

Supplemental Security Income (Title XVI Claims) Initial Determination


DO
Take application
Perform intake interviews
Establish case controls
Determine whether applicant meets income/resource requirement; if so, forward claim to SA (retain SSI technical materials)
Wire technical eligibility data to BDP
Screen certain categories of SSI applicants for VR referral suitability
Complete non-medical development and prepare Title II award in concurrent Title II - XVI filing
Hold claim folders of denied SSI disability applicants for 30 day appeals period
Forward SSI claim at expiration of appeal period to PC or BDI
For Disability Determination
SA
Develop medical evidence
Prepare substantive disability determination
Wire data on disability determination to BDP
In concurrent Title II - XVI filing notify applicant of Title II denial
In concurrent Title II - XVI filing forward Title II allowance to DO for preparation of award
Screen applicant for VR referral suitability
Receive computer list of SSI claims selected for CRS SSI sample review; forward claim to DIRO CRS
DI Regional Office Claims Review Section
Review SA disability decision
Return claim to SA for additional development or decision change (returned SA allowances questioning decisions are handled as reopening)
SSI Sample Claims
Development Returns
Claims folders of SSI denials; concurrent Title II & XVI allowances
Claims folders of SSI-only disability allowances
Disability decision data
Claims folders if SA determinations is unquestioned
List of SSI sample claims
Unappealed SSI-only denials
Title II allowances from a concurrent filing
Income/resource data--technical eligibility
BDP
1. Receive income/resource data
2. Forward computer-prepared notice of technical SSI ineligibility or SSI disability denial to applicant
3. Forward list of computer selected SSI sample claims to SA
Title II allowances without award (conspicious characteristics)
Title II allowances with award (DOFA)
PC
Store SSI claims folders
BDI Headquarters
DIC Authorization
Authorize approved SA Title II allowances
DBP
Process payment action
Establish payment controls and records
Files
Store Title II folders

Abbreviations

BDI	Bureau of Disability Insurance
BDP	Bureau of Data Processing
CRS	Claims Review Section
DO	District office
DOFA	District office finally authorized
DBP	Division of Benefit Payments
DIC	Division of Initial Claims
PC	Program center
SA	State agency
SSI	Supplemental Security Income
VR	Vocational rehabilitation

03/29/74

B. BUREAU OF HEARINGS AND APPEALS—TEXT AND CHARTS

The basic objectives of the Bureau are the following:

1. To provide hearings for individuals who disagree with the determinations made on their claims for retirement, survivors, disability, hospital insurance benefits, or enrollment or termination of enrollment for supplementary medical insurance, or supplemental security income for the aged, blind, and disabled (Titles II, XVI, and XVIII of the Social Security Act, as amended).

2. To provide hearings for providers of services, independent laboratories, and suppliers of portable X-ray services who have been denied the right to participate in the Medicare program (Title XVIII of the Social Security Act, as amended).

3. To provide hearings for individuals who disagree with the determinations made on their claims for benefits in black lung cases (Title IV, Part F, Federal Coal Mine Health and Safety Act of 1969, as amended by Black Lung Benefits Act of 1972).

4. To conduct all hearings in a manner that gives the individual or provider of health care services the opportunity for a fair presentation of his case (Title 5, U.S. Code: Government Organization and Employees Act).

5. To review an administrative law judge's decision upon the request of a party to the hearing or on own motion (Regulation 4, 404.945 and 404.947, Regulation 5, 405.724 and 405.1561, Regulation 10, 410.660—Volume 20, Code of Federal Regulations).

History

1969—Federal Coal Mine Health and Safety Act (Title IV, amended by Black Lung Benefits Act of 1972).

1972—Title changes: Hearing Examiner to Administrative Law Judge; Regional Hearings Representative to Regional Representative, BHA; Assistant Regional Hearings Representative to Assistant Regional Representative, BHA; and Hearing Examiner Office to Hearing Office.

1972—Supplemental Security Income Program (Title XVI).

1973—Office of Regional Chief Administrative Law Judge, Regional Development Center and Regional Appeals Center established per Federal Register, Vol. 38, No. 163, August 23, 1973.

1974—BHA Central Office reorganized to establish the Chief Administrative Law Judge in the Office of the Director, the Division of Policy and Procedure, the Division of Appeals Operations and the Appraisal Staff per Federal Register, Vol. 39, No. 62, March 29, 1974.

Delegation

The Secretary of Health, Education, and Welfare has delegated to the Administrative Law Judges and the Appeals Council of BHA all the duties, powers, and functions relating to conducting hearings and rendering decisions.

Principal staff composition

The Appeals Council is presently authorized eleven members, additional to a chairman and deputy chairman who also serve as director and deputy director of the Bureau. Under direct supervision of the Appeals Council are five (5) Regional Appeals Panels located in Philadelphia, Atlanta, Chicago, Dallas, and San Francisco. The Panels are authorized 12 Appeals Council members and 5 medical advisors. As of June 30, 1974, 482 administrative law judges are authorized to 118 SSA hearings offices and 60 hearing examiners to 108 SSI hearing offices.

Source: "Old-Age, Survivors, Disability, and Health Insurance Provisions: Legislative History, 1935-65;" Robert J. Myers, Chief Actuary, SSA, July 1965; "History of the Provisions of Old-Age, Survivors, Disability, and Health Insurance 1935-72," Office of the Actuary, SSA, February 1973.

Proposed Bureau Mission and Director's Functional Chart
Bureau of Hearings and Appeals
Social Security Administration
Department of Health, Education, and Welfare

SOCIAL SECURITY ADMINISTRATION

BUREAU OF HEARINGS AND APPEALS

Bureau of Hearings and Appeals, BHA - - Plans, directs, coordinates, administers, and appraises the nationwide SSA hearings and appeals process. Reviews appeals filed in Federal Courts on appealed actions or decisions, and recommends whether to defend or to request remand for further action. Provides medical and vocational specialist services to Administrative Law Judges, SSI Hearing Examiners and Appeals Council members. Develops substantive and administrative operating instructions to assure uniform and fair appellate review. Conducts liaison with other components of SSA, DHEW, and other governmental, professional, and private organizations.

OFFICE OF THE BUREAU DIRECTOR

Director: Is responsible to the Commissioner of Social Security for providing overall executive leadership in implementing a fair and impartial hearings and appeals process within SSA. Plans and directs the overall management of BHA to assure that the Bureau's mission is efficiently and effectively accomplished.

Deputy Director: Assists the Bureau Director in carrying out his responsibilities, performs such duties as he requires and acts in his behalf when he is absent.

Chief Administrative Law Judge: Provides professional leadership to the nationwide corps of Administrative Law Judges and SSI Hearing Examiners. Serves as the focal point of communication between the Office of the Bureau Director and the Regional Chief Administrative Law Judges. Directs a professional staff engaged in maintaining close contact with the field hearings organization to obtain and assess the views of the Regional Chief Administrative Law Judges, Administrative Law Judges, and SSI Hearing Examiners on hearings operations.

Proposed Functional Chart
Bureau of Hearings and Appeals
Social Security Administration
Department of Health, Education, and Welfare

OFFICE OF THE BUREAU DIRECTOR

APPEALS COUNCIL

Reviews decisions of Administrative Law Judges and SSI Hearing Examiners involving retirement, survivors, disability, health insurance and supplemental security income benefits under the provisions of titles II, XVI and XVIII of the Social Security Act, as amended, and disability and survivors benefits under Part B of title IV and related provisions of the Federal Coal Mine Health and Safety Act of 1969, as amended, motion of appellants or on its own motion. Examines case records obtaining additional evidence and rendering written decisions or orders which are the Secretary's final decisions or orders, or remands cases to Administrative Law Judges and SSI Hearing Examiners. Determines and recommends action in relation to decisions appealed to the courts. Obtains additional evidence and prepares supplemental decisions on remanded cases, and recommends whether appeals should be taken to higher courts on judicial reversals of the Secretary's decisions.

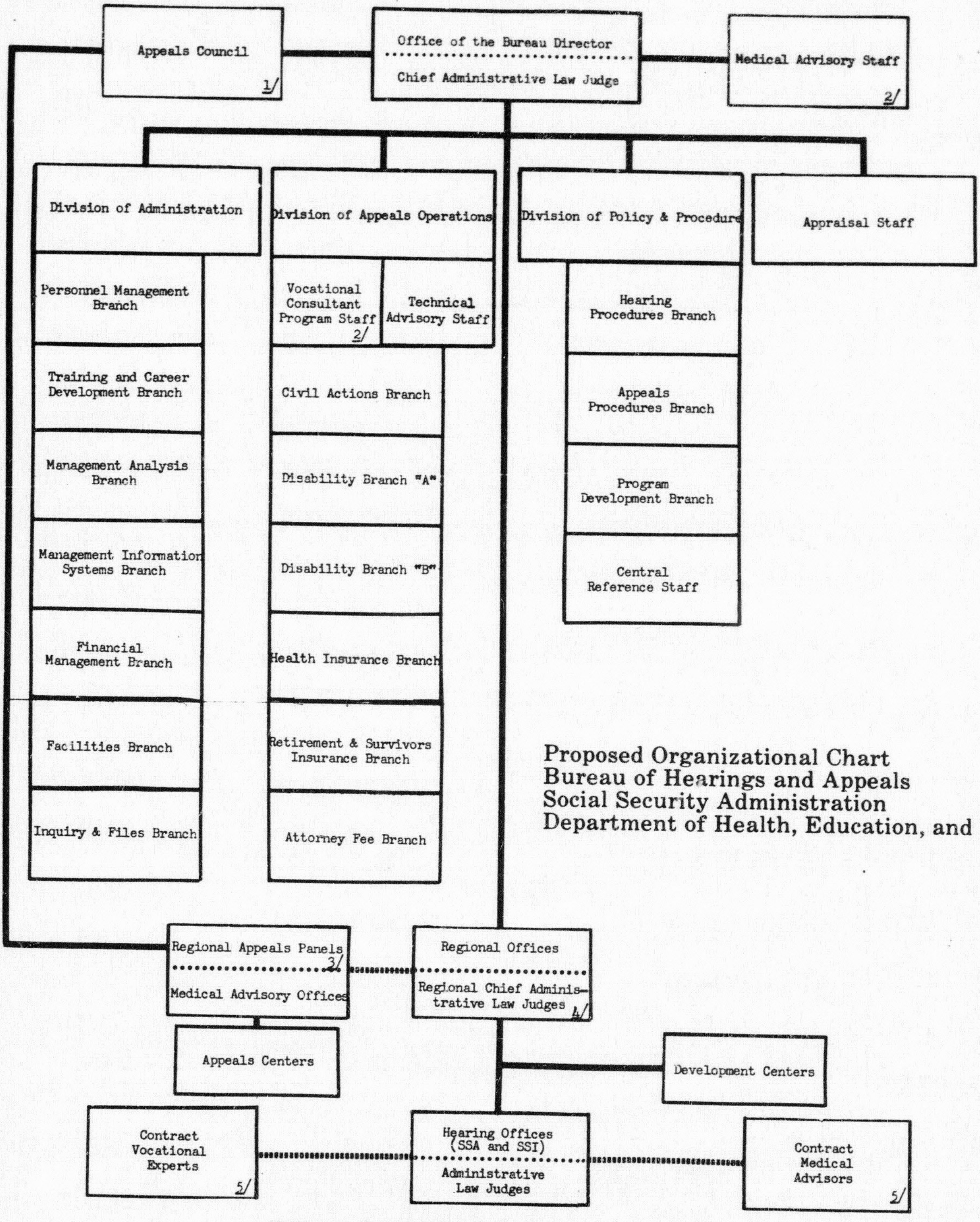
MEDICAL ADVISORY STAFF

Provides medical advisory services to the Appeals Council and other BHA components in the evaluation of disability, health insurance and supplemental security income benefit cases under the provisions of titles II, XVI, and XVIII of the Social Security Act, as amended, and disability and survivors cases under Part B of title IV and related provisions of the Federal Coal Mine Health and Safety Act of 1969, as amended. Assists in medical training of Bureau staff. Negotiates for the services of medical specialists to serve as special consultants to the Appeals Council, and as advisors to Administrative Law Judges, SSI Hearing Examiners, Regional Appeals Panels and Regional Chief Administrative Law Judges. Provides guidance in the effective utilization of medical advisors throughout BHA. Participates in the formulation of medical policies used in the evaluation of disability, health insurance, supplemental security income and black lung benefits cases. Maintains liaison with medical groups to promote program understanding, and to keep abreast of disability evaluation developments and changes in health insurance regulations.

ASSISTANT BUREAU DIRECTOR, ADMINISTRATION DIVISION OF ADMINISTRATION	ASSISTANT BUREAU DIRECTOR, APPEALS OPERATIONS DIVISION OF APPEALS OPERATIONS	ASSISTANT BUREAU DIRECTOR, POLICY AND PROCEDURE DIVISION OF POLICY AND PROCEDURE	APPRAISAL STAFF
Plans, develops and administers BHA's personnel management program, including: recruitment and placement, position classification, incentive awards, employee services, and employee-management relations. Plans, develops, coordinates and conducts BHA employee development and training programs. Plans and directs BHA administrative support activities, such as: space, forms and records, property management, procurement and supply, safety, equipment control and maintenance, preparation of visual aids, and mail/messenger services. Plans and directs BHA's management analysis program, which includes the design, development, implementation, and appraisal of management policies and programs; and researches management techniques and technological developments having possible utility for BHA. Directs BHA's operational and management information systems planning programs; assures effective coordination of the BHA management information system with the SSA system; and maintains a case control and statistical reporting system on the adjudication process. Plans, develops and coordinates BHA's financial management program; and provides financial guidance and control in the areas of budget formulation and execution, work measurement and workload forecasting, pay and travel, position control, contract services, and fiscal operations. Controls and prepares replies to correspondence; develops standards and procedures for correspondence; receives records and indexes; and maintains claims and hearings materials.	Provides advice and assistance to the Appeals Council on the adjudication of cases. Reviews Administrative Law Judge and SSI Hearing Examiner decisions to assist the Appeals Council in deciding whether to assume jurisdiction. Analyzes cases and recommends action to the Appeals Council on appealed claims and litigated cases, and prepares necessary documents to implement the action decided upon by the Appeals Council. Identifies and analyzes problem areas and recommends improvements in the appeals process. Reviews and analyzes fee petitions from attorneys and representatives of claimants for the provision of services at the hearing level, and authorizes payments of appropriate fees, in all cases where fees recommended by Administrative Law Judges and SSI Hearing Examiners exceed their delegated authority, and in all cases at the Appeals Council level. Provides BHA-wide leadership and guidance on all matters pertaining to psychological, vocational, educational and related factors having a bearing on claimants' capacity to work.	Plans, analyzes and develops Bureau-wide policy and procedural guidelines pertaining to the hearing process as performed in regional development centers and hearing offices. Plans, analyzes and develops policy and procedural guidelines pertaining to Appeals Council/Regional Appeals Panel review processes and civil actions processes, and the Appeals Council/Regional Appeals Panel support staffs. Provides an effective system for communicating hearings and appeals policies and procedures, through the issuance of manuals and directives that assure consistent and efficient operations in the best interest of service to the public; and develops and maintains substantive publications, informational material, references and forms relative to the hearings and appeals process. Reviews current and developing trends in administrative law, analyzes policy recommendations, and develops long-range and short-range hearings and appeals policy plans. Provides advice and guidance throughout BHA on matters involving program policies and procedures. Coordinates policy and procedural matters within BHA, and with other SSA components, the Office of the General Counsel, other DHEW components, other Federal agencies and, where appropriate, with private organizations.	Performs a continuing appraisal on the progress being achieved throughout BHA in meeting basic objectives. Conducts a BHA-wide program of appraisals and studies necessary for maintaining an ongoing assessment of overall BHA performance. Recommends actions for implementation or further study by other BHA components.

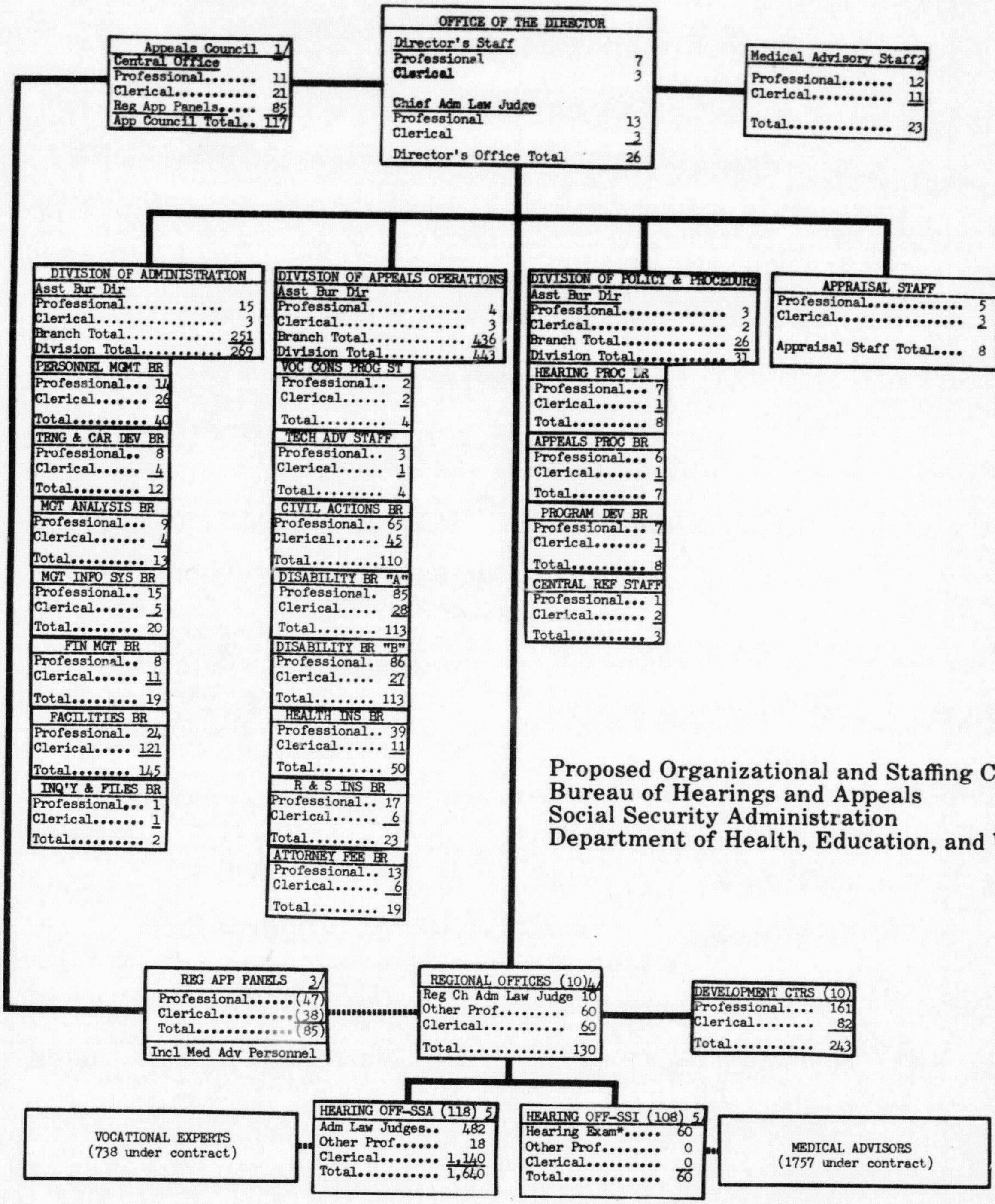
NOTE: Words underlined are added.

SOURCE: Federal Register, Vol. 39, No. 62 - March 29, 1974


Appeals Council 1/
Office of the Bureau Director
Chief Administrative Law Judge
Medical Advisory Staff 2/
Division of Administration
Personnel Management Branch
Training and Career Development Branch
Management Analysis Branch
Management Information Systems Branch
Financial Management Branch
Facilities Branch
Inquiry & Files Branch
Division of Appeals Operations
Vocational Consultant Program Staff 2/
Technical Advisory Staff
Civil Actions Branch
Disability Branch "A"
Disability Branch "B"
Health Insurance Branch
Retirement & Survivors Insurance Branch
Attorney Fee Branch
Division of Policy & Procedure
Hearing Procedures Branch
Appeals Procedures Branch
Program Development Branch
Central Reference Staff
Appraisal Staff
Regional Appeals Panels 3/
Medical Advisory Offices
Regional Offices
Regional Chief Administrative Law Judges 4/
Appeals Centers
Development Centers
Contract Vocational Experts 5/
Hearing Offices (SSA and SSI)
Administrative Law Judges
Contract Medical Advisors 5/

Proposed Organizational Chart
Bureau of Hearings and Appeals
Social Security Administration
Department of Health, Education, and Welfare

1/ Exercises line surveillance responsibility over regional counterpart.
2/ Exercises staff surveillance responsibility over regional counterpart.
3/ Regional Appeals Panels are provided for 5 of the 10 regional offices: Philadelphia, Atlanta, Chicago, Dallas, San Francisco.
4/ Serves as Regional Representative. Provides administrative support to the Regional Appeals Panels and Appeals Centers.
5/ The Medical Advisory and Vocational Consultant Program Staffs provide contract professional services to the Administrative Law Judges.


OFFICE OF THE DIRECTOR
Director's Staff
Professional 7
Clerical 3
Chief Adm Law Judge
Professional 13
Clerical 3
Director's Office Total 26
Appeals Council 1/
Central Office
Professional........ 11
Clerical.......... 21
Reg App Panels..... 85
App Council Total.. 117
Medical Advisory Staff 2/
Professional....... 12
Clerical.......... 11
Total.............. 23
DIVISION OF ADMINISTRATION
Asst Bur Dir
Professional............ 15
Clerical................ 3
Branch Total............ 251
Division Total.......... 269
PERSONNEL MGMT BR
Professional... 14
Clerical....... 26
Total.......... 40
TRNG & CAR DEV BR
Professional.. 8
Clerical...... 4
Total......... 12
MGT ANALYSIS BR
Professional... 9
Clerical....... 4
Total.......... 13
MGT INFO SYS BR
Professional.. 15
Clerical...... 5
Total......... 20
FIN MGT BR
Professional.. 8
Clerical...... 11
Total......... 19
FACILITIES BR
Professional. 24
Clerical..... 121
Total........ 145
INQ'Y & FILES BR
Professional... 1
Clerical....... 1
Total.......... 2
DIVISION OF APPEALS OPERATIONS
Asst Bur Dir
Professional............ 4
Clerical................ 3
Branch Total............ 436
Division Total.......... 443
VOC CONS PROG ST
Professional.. 2
Clerical...... 2
Total......... 4
TECH ADV STAFF
Professional.. 3
Clerical...... 1
Total......... 4
CIVIL ACTIONS BR
Professional.. 65
Clerical...... 45
Total.........110
DISABILITY BR "A"
Professional. 85
Clerical..... 28
Total........ 113
DISABILITY BR "B"
Professional. 86
Clerical..... 27
Total........ 113
HEALTH INS BR
Professional.. 39
Clerical...... 11
Total......... 50
R & S INS BR
Professional.. 17
Clerical...... 6
Total......... 23
ATTORNEY FEE BR
Professional.. 13
Clerical...... 6
Total......... 19
DIVISION OF POLICY & PROCEDURE
Asst Bur Dir
Professional............ 3
Clerical................ 2
Branch Total............ 26
Division Total.......... 31
HEARING PROC BR
Professional... 7
Clerical....... 1
Total.......... 8
APPEALS PROC BR
Professional... 6
Clerical....... 1
Total.......... 7
PROGRAM DEV BR
Professional... 7
Clerical....... 1
Total.......... 8
CENTRAL REF STAFF
Professional... 1
Clerical....... 2
Total.......... 3
APPRAISAL STAFF
Professional........... 5
Clerical............... 3
Appraisal Staff Total.... 8
REG APP PANELS 3/
Professional......(47)
Clerical..........(38)
Total.............(85)
Incl Med Adv Personnel
REGIONAL OFFICES (10) 4/
Reg Ch Adm Law Judge 10
Other Prof......... 60
Clerical........... 60
Total.............. 130
DEVELOPMENT CTRS (10)
Professional.... 161
Clerical........ 82
Total........... 243
VOCATIONAL EXPERTS
(738 under contract)
HEARING OFF-SSA (118) 5/
Adm Law Judges.. 482
Other Prof...... 18
Clerical........ 1,140
Total........... 1,640
HEARING OFF-SSI (108) 5/
Hearing Exam*..... 60
Other Prof........ 0
Clerical.......... 0
Total............. 60
MEDICAL ADVISORS
(1757 under contract)

Proposed Organizational and Staffing Chart
Bureau of Hearings and Appeals
Social Security Administration
Department of Health, Education, and Welfare

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4/ Serves as Regional Representative. Provides administrative support to the Regional Appeals Panels and Appeals Centers.
5/ The Medical Advisory and Vocational Consultant Program Staffs provide contract professional services to the Administrative Law Judges.

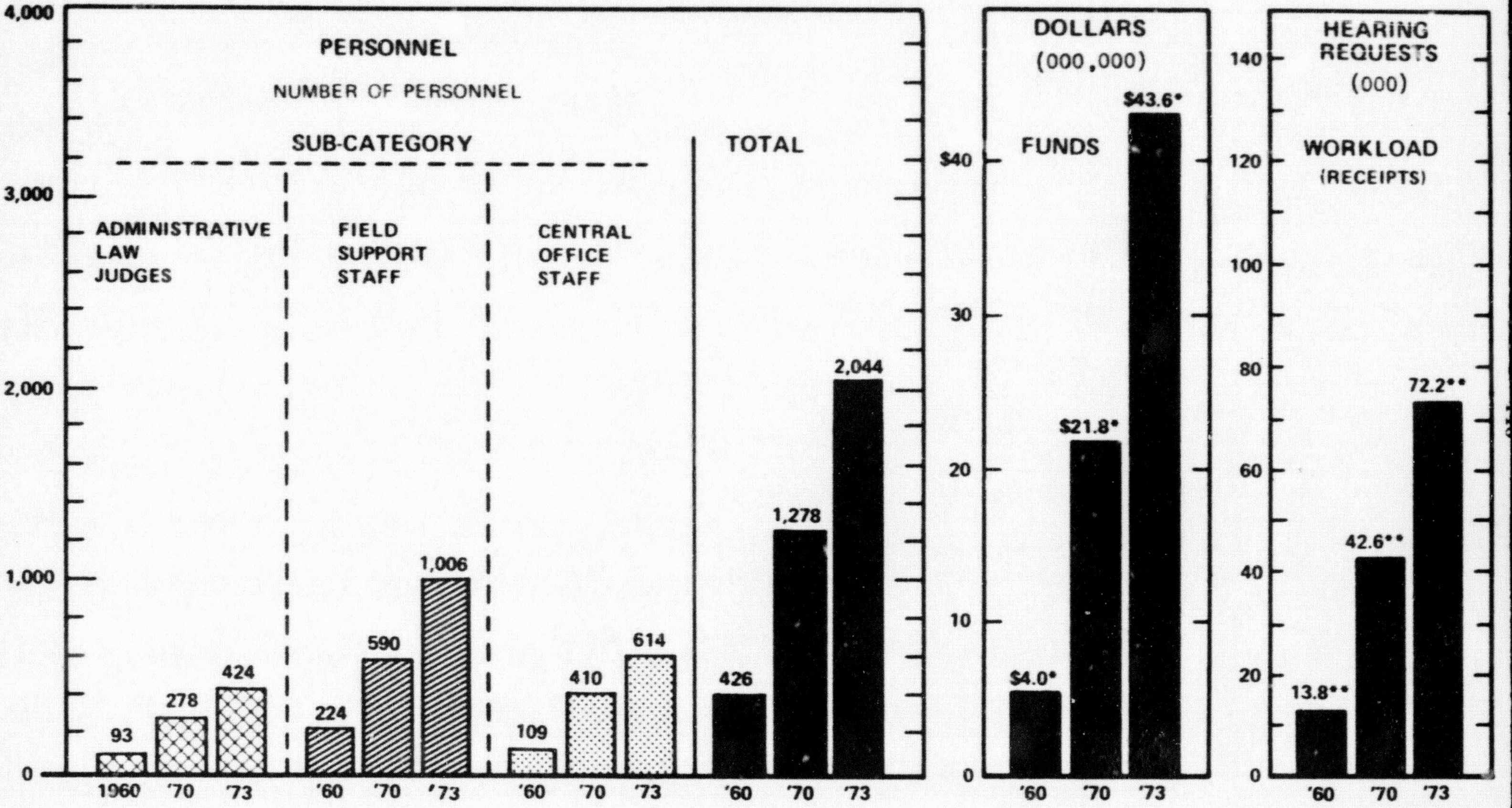
* Not to be hired until July 1, 1974

RECAPITULATION	
Director's Office Total . . .	26
Appeals Council	117
Medical Advisory Staff	23
Appraisal Staff	8
Div of Administration	269
Div of Appeals Operations . . .	443
Div of Policy & Procedure . .	31
Total Central Office	917
Total Field Offices	2,073
Total Full Time Perm Staff .	2,990

SOURCE: Budget Management Section
NOTE: Data reported as of April 26, 1974, for FY 1974
NOTE: Clerical authorizations to Chief Administrative Law Judge were increased from 3 to 7 as of May 24, 1974.

GROWTH YARD STICKS

Bureau of Hearings and Appeals FY 1960 - 73

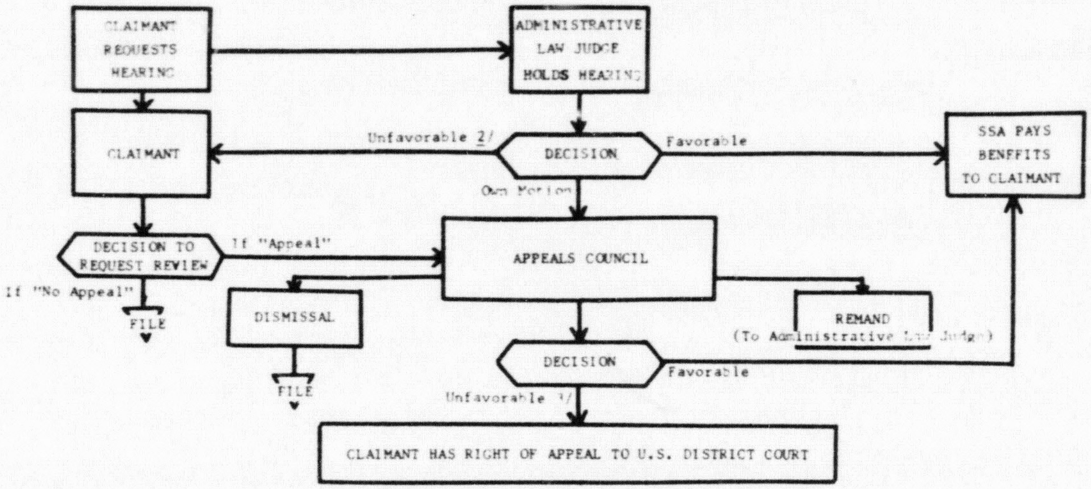


SOURCE: Budget Management Section

NOTE 1. Personnel are defined as permanent, full-time, on-duty personnel and include LWOPs.
NOTE 2. FY 1973 funds are estimated.
NOTE 3. Hearing requests include 7,824 black lung requests for FY 1973.
NOTE 4. Administrative Law Judge data for FY 1973 exclude 38 temporary positions

*Rounded to nearest $100,000.
**Rounded to nearest 1,000.

FLOW CHART OF THE APPEALS PROCESS IN TITLE II CASES[1]


CLAIMANT REQUESTS HEARING
ADMINISTRATIVE LAW JUDGE HOLDS HEARING
CLAIMANT
Unfavorable 2/
DECISION
Favorable
SSA PAYS BENFFITS TO CLAIMANT
Own Motion
DECISION TO REQUEST REVIEW
If "Appeal"
APPEALS COUNCIL
If "No Appeal"
FILE
DISMISSAL
FILE
REMAND
(To Administrative Law Judge)
DECISION
Favorable
Unfavorable 3/
CLAIMANT HAS RIGHT OF APPEAL TO U.S. DISTRICT COURT

BASIC STEPS IN THE APPEALS PROCESS

1. Administrative law judge holds hearing upon receipt of claimant's request and makes decision.

2. Subject to Own Motion review by Appeals Council, if the administrative law judge's decision is favorable, SSA pays benefits. (In a Title XVIII case involving a provider of services or independent laboratory, SSA certifies or continues certification for participation or coverage in the program).

3. If the administrative law judge's decision is unfavorable, a claimant has sixty days to appeal to the Appeals Council. The granting of review is discretionary.

4. The Appeals Council reviews the administrative law judge's decision upon request of claimant or on its Own Motion.

5. If the Appeals Council decision is favorable, SSA pays benefits as for Step 2.

6. If the Appeals Council decision is unfavorable, claimant has sixty days to appeal to a U.S. district court.

7. If the Appeals Council finds that the administrative law judge's decision is not proper and that additional evidence is required, it may vacate the decision and remand the case to an administrative law judge, or it may develop the case and issue its own decision.

1/ The procedure for Title XVIII of the Social Security Act and Title IV (Black Lung Benefits) of the Federal Coal Mine Health and Safety Act of 1969 is essentially as depicted here for Title II.

2/ A negligible number of decisions unfavorable to claimants is taken on Own Motion review by the Appeals Council. Also, "Unfavorable" includes a small number of partially favorable decisions which claimants may appeal.

3/ Includes Denials of Request for Review.

2. State Agency Operation

A. Organization, Staffing, Unit Costs, and Major Areas of Expenditures

State agencies pursuant to an agreement with the Secretary are responsible for making determinations of disability on the basis of standards and guidelines provided by the Department. The legal and administrative framework for the agreements with State agencies, primarily State vocational rehabilitation agencies, is set forth in Sections 221 and 222 of the Social Security Act. The relationship between State agency and SSA is essentially an agent-principal relationship.

The Department now has Section 221 agreements with 54 State agencies for making disability determinations. These cover all the States (including a separate agency for the blind in South Carolina), District of Columbia, Puerto Rico and Guam. In all but six States, a unit of the vocational rehabilitation agency has been designated by the Governor to handle SSA's disability determinations. In four States (Oklahoma, North Carolina, Washington, and New York) the designated unit is in the welfare agency. In Arkansas and Idaho, the unit is an independent agency. The responsibilities of the State agencies and of SSA toward each other are set forth in the model agreement.

ORGANIZATION OF A TYPICAL DISABILITY DETERMINATION UNIT (DDU)

Various nomenclature is applied by State governments to the components which are established within State agencies to carry out the agreement between the parent agency and the Secretary. For convenience Bureau of Disability Insurance (BDI) uses the generic term, "disability determination unit" (DDU's).

DDU's typically are staffed with a director; a chief medical consultant and a staff of full time or part time physicians; an examining group composed of supervisors, disability examiners and, usually, vocational specialists; and clerical and sometimes accounting support.

The volume of disability claims may justify only a very small DDU staff in some States and in others the volume is so large that several DDU's have been established.

DDU's with a sufficient number of employees to permit specialization have established separate units for handling reconsiderations and some have separate units for continuing disability determinations. All but the smallest DDU's have also established separate positions or units for quality assurance. Nine DDU's which had the largest Black Lung claims load set up special units but these units have been or are about to be phased out. It is generally planned to integrate Supplemental Security Income (SSI) claims work, however, with Social Security work.

Table 4.—*Fiscal year 1973 obligations, approved fiscal year 1974 spending allowances, fiscal year 1973 man year usage, and fiscal year 1974 man year allowances, by State agency*

Regional offices and States	1973 obligations	1974 approved budget	1973 man years used	1974 man years
United States	$92, 032, 308. 58	$174, 737, 450	4, 503. 683	8, 465. 79
Boston:				
Connecticut	1, 047, 777. 89	2, 118, 553	55. 2	117. 7
Maine	350, 506. 48	841, 904	21. 3	44. 2
Massachusetts	2, 019, 441. 68	3, 628, 814	112. 1	180. 86
New Hampshire	190, 038. 64	529, 229	12. 6	32. 0
Rhode Island	356, 521. 14	914, 808	19. 2	45. 74
Vermont	112, 532. 04	318, 422	10. 1	21. 0
New York:				
New Jersey	2, 948, 710. 25	6, 359, 673	162. 0	317. 5
New York	8, 457, 444. 63	16, 012, 151	435. 0	718. 5
Puerto Ri	1, 984, 938. 97	2, 375, 706	121. 5	133. 0
Philadelphia:				
Delaware:				
Vocational rehabilitation	312, 914. 86	504, 284	14. 43	23. 57
Blind				
District of Columbia	470, 948. 45	839, 349	30. 5	37. 05
Maryland	1, 368, 153. 06	3, 220, 160	77. 0	162. 50
Pennsylvania	6, 040, 375. 95	10, 682, 018	220. 5	500. 0
Virginia	2, 286, 883. 74	4, 198, 558	100. 8	206. 50
West Virginia	2, 204, 896. 14	2, 828, 235	80. 5	126. 00
Atlanta:				
Alabama	2, 158, 318. 95	4, 824, 405	85. 9	208. 00
Florida	3, 041, 890. 70	6, 790, 961	150. 0	369. 70
Georgia	2, 294, 264. 38	3, 974, 029	111. 6	200. 00
Kentucky	2, 530, 799. 60	2, 654, 643	70. 1	111. 00
Mississippi	1, 091, 830. 90	2, 754, 737	60. 17	148. 20
North Carolina	1, 958, 272. 84	5, 240, 532	99. 0	244. 00
South Carolina:				
Vocational rehabilitation	1, 388. 655. 56	2, 911, 068	63. 42	139. 10
Blind	7, 682. 74	30, 039	1. 03	2. 0
Tennessee	1, 759, 960. 81	3, 530, 943	78. 9	161. 90
Chicago:				
Illinois	3, 706, 008. 93	6, 460, 379	197. 4	330. 0
Indiana	1, 957, 745. 00	3, 958, 967	96. 4	218. 00
Michigan	4, 635, 724. 15	9, 207, 245	192. 1	402. 0
Minnesota	1, 242, 200. 36	2, 136, 272	53. 7	102. 5
Ohio	4, 047, 422. 78	6, 645, 554	170. 2	318. 0
Wisconsin	1, 493, 753. 25	2, 648, 375	84. 8	132. 0
Dallas:				
Arkansas	844, 432. 67	1, 261, 739	60. 25	70. 2
Louisiana	1, 718, 799. 08	5, 331, 086	94. 75	257. 3
New Mexico	520, 337. 15	692, 200	23. 84	32. 8
Oklahoma	978, 076. 70	1, 514, 761	62. 62	76. 2
Texas	4, 157, 460. 00	9, 931, 334	208. 625	458. 0
Kansas City:				
Iowa	771, 343. 87	1, 453, 441	42. 46	685.
Kansas	727, 992. 00	1, 488, 006	35. 9	69. 0
Missouri	1, 665, 056. 53	3, 068, 341	85. 15	124. 2
Nebraska	379, 486. 00	708, 919	21. 375	44. 0
Denver:				
Colorado	902, 512. 82	1, 655, 539	37. 854	83. 8
Montana	284, 730. 08	499, 434	14. 73	22. 737
North Dakota	135, 309. 00	244, 971	9. 4	14. 80
South Dakota	171, 047. 22	300, 252	10. 41	15. 65
Utah	343, 225. 90	678, 010	14. 457	30. 95
Wyoming	105, 897. 65	165, 882	6. 272	8. 423
San Francisco:				
Arizona	719, 640. 30	1, 172, 968	39. 0	61. 1
California	10, 474, 491. 56	18, 895, 052	566. 6	982. 5
Guam	5, 410. 60	19, 249	. 83	. 83
Hawaii	280, 855. 97	535, 824	16. 31	29. 8
Nevada	273, 513. 53	631, 932	13. 0	25. 8
Seattle:				
Alaska	125, 037. 74	287, 221	4. 1	10. 0
Idaho	373, 428. 65	666, 897	19. 0	30. 68
Oregon	1, 084, 261. 41	1, 878, 366	54. 3	86. 0
Washington	1, 523, 347. 28	2, 516, 013	75. 0	110. 0

TABLE 5.—*Social security disability determination unit costs (excluding consultative medical examinations), fiscal year 1973*

Regional offices and States	Total cases processed	Disability insurance obligations	Average cost per case
United States	1, 289, 143	$64, 450, 716	$50. 00
Boston:			
Connecticut	14, 662	831, 597	56. 72
Maine	6, 472	270, 155	41. 74
Massachusetts	27, 770	1, 624, 319	58. 49
New Hampshire	4, 080	151, 811	37. 21
Rhode Island	5, 625	286, 216	50. 88
Vermont	2, 836	99, 567	35. 11
New York:			
New Jersey	39, 794	2, 194, 026	55. 13
New York	104, 565	7, 137, 184	68. 26
Puerto Rico	23, 981	1, 174, 326	48. 97
Philadelphia:			
Delaware:			
Vocational rehabilitation	3, 267	244, 840	74. 94
Blind			
District of Columbia	6, 044	330, 809	54. 73
Maryland	20, 777	895, 960	43. 12
Pennsylvania	73, 763	3, 106, 933	42. 12
Virginia	29, 038	1, 247, 267	42. 95
West Virginia	17, 908	760, 021	42. 44
Atlanta:			
Alabama	29, 500	1, 237, 507	41. 95
Florida	46, 607	2, 211, 930	47. 46
Georgia	34, 034	1, 625, 076	47. 75
Kentucky	27, 357	917, 385	33. 53
Mississippi	18, 604	832, 799	44. 76
North Carolina	35, 763	1, 507, 558	42. 15
South Carolina:			
Vocational rehabilitation	20, 439	1, 121, 088	54. 85
Blind	204	7, 343	35. 99
Tennessee	29, 648	1, 017, 040	34. 30
Chicago:			
Illinois	59, 072	2, 588, 764	43. 82
Indiana	31, 105	1, 277, 499	41. 07
Michigan	57, 180	3, 361, 678	58. 79
Minnesota	15, 620	1, 007, 904	64. 53
Ohio	59, 259	2, 531, 739	42. 72
Wisconsin	21, 400	1, 209, 264	56. 51
Dallas:			
Arkansas	17, 944	592, 591	33. 02
Louisiana	28, 684	1, 241, 551	43. 28
New Mexico	6, 690	338, 694	50. 63
Oklahoma	15, 997	657, 777	41. 12
Texas	64, 773	3, 026, 452	46. 72
Kansas City:			
Iowa	12, 182	503, 963	41. 37
Kansas	9, 500	541, 785	57. 03
Missouri	27, 260	1, 180, 163	43. 29
Nebraska	6, 522	294, 800	45. 20
Denver:			
Colorado	10, 412	595, 940	57. 23
Montana	4, 426	192, 659	43. 53
North Dakota	2, 460	109, 981	44. 71
South Dakota	2, 812	133, 264	47. 39
Utah	4, 395	215, 532	49. 04
Wyoming	1, 613	71, 062	44. 06
San Francisco:			
Arizona	11, 358	513, 299	45. 19
California	146, 491	8, 821, 501	60. 22
Guam	59	4, 751	80. 53
Hawaii	3, 341	244, 503	73. 18
Nevada	3, 605	225, 518	62. 56
Seattle:			
Alaska	1, 196	100, 320	83. 88
Idaho	4, 640	285, 796	61. 59
Oregon	15, 574	762, 479	48. 96
Washington	20, 835	986, 730	47. 36

TABLE 6.—*Personnel involved in the processing of initial social security (title II) disability determinations: Comparison of salary levels, State and Federal agency*

STATE AGENCIES [1]		BUREAU OF DISABILITY INSURANCE (BDI)[3]	
Director or supervisor of disability determination unit [2]	$14, 227	Director, Division of Initial Claims (GS-15)[4]	$31, 089
Assistant director	13, 325	Deputy Director (GS-14)	26, 671
		Branch Chief (GS-14)	26, 671
First-line supervisor	11, 470	Section Chief (GS-13)	22, 744
Vocational specialist	10, 358	Vocational Specialist (GS-13)	22, 744
Quality appraisal specialist	10, 566	Quality Appraisal Specialist (GS-12)	19, 246
		Consultant (GS-12)	19, 246
Initial claims examiner	9, 012	Examiner (GS-11)	16, 627
Examiner trainee	8, 229	Examiner-trainee (GS-9)	13, 385
Secretary-stenographer	5, 839	Secretary-Stenographer (GS-4)	7, 918
Typist	5, 082	Typist (GS-3)	7, 050
General clerk	5, 309	Clerk (GS-3)	7, 050

[1] Salary listed is median for all State agencies based on minimum salary in FY '74.

[2] State disability determination unit supervisors oversee staffs ranging in size from 10-1,000 personnel with the average agency running between 200-250 people.

[3] Salary level at 4th step of GS rating in FY '74.

[4] Oversees a staff of slightly over 700 persons who in addition to reviewing State disability determinations (Division of Initial Claims prepares determinations in non-State cases) are responsible for the preparation and authorization of benefit awards to "allowed" applicants.

TABLE 7.—*State agency manpower utilization and estimated obligations, and State agency staffing, as of Apr. 20, 1974*

State	Man-years authorized	Full time and part time on duty	Man-years used	Staff to hire	Personnel staffing obligations	Consultative examination obligations	All other obligations	Total obligations	Percent of authorized budget	Funds available to obligate
United States	8, 528. 759	8, 487. 0	5, 597. 9	6, 753. 2	63,052,500. 50	27,824,912. 25	25,638,043. 00	116,515,455. 00	66. 8	57,840,356. 00
Connecticut	117. 700	108. 8	71. 3	132. 2	815, 600. 02	239, 645. 29	416, 409. 91	1, 471, 555. 22	69. 5	646, 897. 78
Maine	44. 200	42. 3	26. 1	51. 6	281, 517. 25	107, 813. 40	150, 612. 88	539, 943. 52	64. 1	301, 960. 48
Massachusetts	180. 860	187. 7	131. 3	70. 0	1, 456, 601. 66	562, 313. 77	468, 373. 72	2, 487, 289. 12	68. 5	1, 141, 524. 87
New Hampshire	32. 000	25. 3	15. 6	60. 2	157, 688. 80	36, 997. 49	56, 401. 64	251, 087. 93	47. 4	278, 141. 08
Rhode Island	45. 740	38. 2	27. 1	59. 0	337, 139. 87	82, 020. 69	67, 330. 63	486, 491. 19	53. 2	428, 316. 81
Vermont	21. 000	18. 5	12. 2	27. 1	108, 838. 23	18, 279. 69	47, 570. 38	174, 688. 30	54. 9	143, 733. 70
New Jersey	317. 500	309. 4	226. 9	161. 8	2, 430, 407. 56	898, 286. 49	502, 825. 14	3, 831, 519. 16	60. 2	2, 528, 153. 87
New York	718. 500	724. 7	455. 5	643. 0	6, 470, 981. 00	1, 646, 944. 45	2, 592, 792. 75	10, 710, 718. 12	66. 9	5, 301, 432. 87
Puerto Rico	133. 000	130. 8	100. 0	40. 5	798, 690. 70	819, 341. 32	207, 793. 97	1, 825, 825. 98	76. 9	549, 880. 03
Delaware	23. 570	21. 4	16. 6	14. 9	201, 011. 25	71, 286. 40	64. 244. 42	336, 542. 07	66. 7	167, 741. 93
District of Columbia	37. 050	29. 0	20. 6	56. 6	245, 849. 62	107, 812. 96	165, 373. 51	519, 036. 09	61. 8	320, 312. 91
Maryland	162. 500	138. 9	89. 8	238. 9	952, 974. 37	511, 478. 42	417, 716. 94	1, 882, 169. 72	58. 4	1, 337, 990. 28
Pennsylvania	500. 000	425. 2	295. 7	637. 3	3, 439, 139. 50	1, 786, 527. 78	1, 124, 541. 52	6, 350, 208. 75	61. 2	4, 020, 700. 25
Virginia	205. 500	208. 3	142. 8	122. 7	1, 232, 095. 58	593, 713. 25	646, 636. 84	2, 472, 445. 66	61. 2	1, 569, 969. 34
West Virginia	126. 000	125. 1	68. 3	174. 7	454, 666. 68	336, 708. 38	671, 936. 13	1, 760, 311. 17	69. 8	760, 597. 84
Alabama	208. 000	200. 5	137. 0	168. 6	1, 175, 717. 91	661, 642. 84	980, 219. 29	2, 317, 580. 00	60. 8	1, 815, 840. 00
Florida	369. 700	354. 9	278. 5	119. 4	2, 649, 840. 66	994, 546. 84	1, 930, 172. 58	5, 574, 560. 00	92. 5	1, 184, 055. 00
Georgia	200. 000	210. 3	138. 8	108. 1	1, 386, 403. 53	568, 761. 24	551, 232. 18	2, 506, 396. 94	63. 1	1, 467, 632. 06
Kentucky	111. 000	147. 0	79. 6	16. 0	623, 263. 37	668, 738. 63	614, 702. 78	1, 906, 704. 78	80. 9	449, 620. 22
Mississippi	148. 200	140. 9	85. 0	187. 8	843, 050. 30	373, 065. 08	653, 906. 23	1, 870, 021. 61	67. 9	884, 715. 41
North Carolina	244. 000	247. 2	148. 9	247. 1	1, 555, 022. 64	653, 798. 33	652, 828. 53	2, 861, 649. 50	54. 8	2, 360, 803. 57
South Carolina [1]	139. 100	141. 1	98. 0	72. 5	1, 165, 464. 08	337, 036. 53	478, 053. 92	1, 980, 554. 50	68. 0	930, 513. 50

Tennessee	161. 900	163. 0	110. 9	102. 3	990, 402. 45	861, 014. 09	345, 237. 31	2, 196, 653. 81	65. 0	1, 182, 703. 19
Illinois	330. 000	338. 6	224. 4	210. 4	2, 564, 596. 72	766, 856. 06	760, 799. 95	4, 092, 252. 72	64. 6	2, 246, 651. 31
Indiana	218. 000	182. 6	138. 4	231. 2	1, 206, 183. 80	476, 549. 84	287, 030. 46	1, 969, 764. 08	51. 3	1, 870, 629. 94
Michigan	402. 000	344. 7	253. 2	429. 1	3, 321, 254. 72	1, 407, 733. 03	946, 523. 75	5, 675, 511. 50	61. 9	3, 491, 477. 50
Minnesota	102. 500	90. 1	74. 9	53. 6	807, 833. 47	267, 110. 15	417, 046. 35	1, 491, 989. 95	69. 8	644, 282. 06
Ohio	318. 000	311. 1	196. 4	321. 0	2, 420, 206. 37	1, 086, 377. 70	860, 099. 49	4, 366, 683. 50	66. 5	2, 204, 397. 50
Wisconsin	132. 000	135. 2	38. 8	89. 3	1, 230, 981. 69	367, 976. 52	323, 848. 32	1, 922, 806. 52	72. 6	725, 568. 50
Arkansas	104. 000	101. 9	58. 1	136. 6	661, 162. 24	386, 090. 19	203, 495. 53	1, 250, 747. 95	99. 1	10, 991. 05
Louisiana	257. 300	242. 3	168. 2	221. 1	1, 700, 190. 41	839, 162. 67	937, 784. 33	3, 477, 137. 37	65. 2	1, 853, 948. 62
New Mexico	32. 800	48. 8	24. 8	−7. 0	316, 479. 72	300, 541. 50	159, 263. 90	776, 285. 11	112. 1	−84, 085. 11
Oklahoma	76. 200	48. 4	49. 7	89. 3	520, 567. 20	431, 303. 23	122, 937. 16	1, 074, 807. 58	71. 0	439, 953. 42
Texas	458. 000	458. 5	280. 1	468. 6	3, 197, 558. 37	1, 892, 948. 73	1, 156, 584. 33	6, 247, 091. 37	62. 9	3, 684, 242. 62
Iowa	68. 500	67. 4	42. 7	66. 8	404, 838. 53	316, 538. 23	164, 466. 27	885, 843. 02	61. 4	558, 008. 98
Kansas	69. 000	66. 4	40. 9	79. 6	402, 335. 14	210, 905. 80	347, 960. 50	961, 201. 43	64. 9	520, 115. 58
Missouri	124. 200	144. 5	88. 8	39. 8	1, 029, 504. 75	652, 842. 89	470, 594. 46	2, 152, 942. 09	70. 6	897, 145. 91
Nebraska	44. 000	54. 0	31. 7	10. 1	319, 370. 62	107, 375. 17	85, 273. 91	512, 019. 70	72. 2	196, 899. 30
Colorado	83. 800	84. 7	49. 3	94. 6	597, 423. 83	217, 493. 02	350, 811. 65	1, 165, 728. 48	71. 1	473, 982. 52
Montana	22. 737	28. 4	15. 5	9. 1	169, 535. 85	89, 539. 40	117, 894. 43	376, 969. 68	75. 5	122, 464. 32
North Dakota	14. 800	19. 3	10. 6	2. 8	100, 450. 51	44, 685. 40	40, 266. 84	185, 402. 75	75. 7	59, 568. 25
South Dakota	15. 650	20. 3	9. 6	11. 3	99, 374. 24	42, 127. 30	57, 953. 16	199, 454. 70	66. 4	100, 797. 30
Utah	30. 990	31. 0	19. 1	30. 8	209, 381. 44	104, 089. 35	110, 265. 81	424, 236. 59	62. 6	253, 773. 41
Wyoming	8. 473	11. 2	5. 9	1. 8	57, 304. 89	13, 074. 68	35, 173. 75	185, 553. 32	63. 6	60, 328. 68
Arizona	61. 100	76. 4	44. 2	11. 3	439, 041. 41	258, 629. 14	116, 357. 04	814, 027. 59	69. 4	358, 940. 41
California	932. 500	1, 089. 9	690. 8	426. 8	8, 933, 300. 25	2, 797, 476. 84	2, 758, 857. 94	14, 489, 634. 87	76. 9	4, 357, 572. 25
Hawaii	29. 800	33. 3	17. 6	30. 0	258, 230. 78	40, 520. 48	119, 305. 45	418, 056. 71	78. 0	117, 767. 30
Nevada	25. 800	24. 9	18. 4	13. 6	222, 982. 11	62, 709. 85	79, 040. 21	384, 732. 17	57. 7	267, 199. 84
Alaska	11. 000	11. 2	6. 3	13. 2	88, 000. 72	29, 237. 61	51, 610. 40	168, 848. 73	56. 5	129, 902. 27
Idaho	31. 680	34. 1	23. 1	10. 5	258, 801. 05	136, 105. 77	107, 561. 45	502, 468. 27	75. 3	164, 428. 73
Oregon	95. 000	110. 7	64. 4	53. 4	778, 523. 54	398, 889. 40	274, 716. 09	1, 452, 129. 02	77. 3	426, 236. 98
Washington	130. 000	140. 6	85. 3	91. 7	1, 038, 589. 84	824, 178. 29	333, 901. 34	2, 196, 669. 44	53. 7	1, 894, 343. 56

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[1] Vocational rehabilitation.

The following tables show State-by-State for the years 1961 and 1966–73 the total expenditures, the amount spent for medical examinations, the average number of employees on disability work, the number of cases completed, and the percent of cases requiring additional evidence and medical evidence, respectively.

TABLE 8.—*Selected data on State agency operations, fiscal year 1961*

State agencies	Expenditures (in thousands of dollars)		Average number of employees on disability work	Disability cases completed		Percent of all cases which require additional evidence	
	Total	Medical examinations		Total	Initial determination	Evidence of all types	Purchase medical evidence
United States	16,983.6	7,292.6	1,497.2	472,135	364,367	55.5	34.2
Alabama	411.8	208.0	32.3	12,736	9,924	58.2	35.7
Alaska	11.6	1.9	1.2	187	131	44.1	8.6
Arizona	142.6	42.5	14.7	3,317	2,537	52.9	29.8
Arkansas	185.8	77.9	16.5	6,347	4,568	58.9	30.4
California	1,479.8	543.9	113.3	38,267	30,456	49.0	27.1
Colorado	125.9	46.0	12.4	3,975	3,277	43.8	19.8
Connecticut	176.3	30.7	22.4	6,072	4,740	43.7	21.6
Delaware:							
Public welfare	1.0	0	.1	46	36	80.0	0
Vocational rehabilitation	26.0	7.3	3.3	1,127	877	34.1	19.0
District of Columbia	62.2	20.3	5.4	2,346	1,845	44.3	30.0
Florida	501.1	241.4	39.1	15,553	12,181	58.1	37.6
Georgia	560.9	290.7	39.6	15,051	11,677	57.1	36.9
Guam	---	---	---	---	---	---	---
Hawaii	48.1	11.9	5.4	1,530	1,185	35.9	13.0
Idaho	43.8	16.0	4.4	1,407	1,043	38.4	23.7
Illinois	947.1	481.8	83.7	21,846	16,240	59.8	43.9
Indiana	305.5	167.8	28.9	11,006	8,127	48.7	34.6
Iowa	155.8	60.3	15.5	5,321	4,401	63.3	36.8
Kansas	193.7	95.2	15.3	4,663	3,791	48.9	35.6
Kentucky	397.8	165.4	49.4	11,101	7,445	48.9	41.1
Louisiana	440.2	221.3	29.6	11,598	8,710	64.2	48.9
Maine	65.7	20.7	6.6	2,506	1,965	56.4	26.0
Maryland	171.7	83.3	13.0	7,632	5,974	45.6	27.1
Massachusetts	476.3	149.7	47.8	12,157	9,504	56.4	29.3
Michigan	774.6	338.1	59.0	18,403	14,975	60.6	35.6
Minnesota	227.9	90.6	21.2	6,685	5,055	59.5	25.3
Mississippi	257.6	87.0	23.0	7,047	5,009	60.3	36.8
Missouri	395.0	205.1	30.4	13,542	10,579	53.0	26.9
Montana	66.5	28.3	5.9	1,804	1,283	40.1	24.8
Nebraska	72.2	16.2	8.7	2,513	1,912	46.8	13.6
Nevada	86.0	12.2	2.8	546	445	56.6	34.8
New Hampshire	45.5	10.1	5.7	1,273	1,021	56.0	24.8
New Jersey	477.9	184.6	47.3	14,479	11,341	49.9	40.4
New Mexico	99.6	50.1	5.9	2,195	1,707	61.8	34.1
New York	1,500.2	520.2	159.3	40,417	31,574	55.6	32.7
North Carolina	536.8	284.9	36.2	15,098	12,068	64.0	39.9
North Dakota	38.5	11.0	4.4	1,189	868	48.1	22.0
Ohio	688.3	302.8	66.7	18,616	14,537	59.2	38.9
Oklahoma	223.8	90.8	24.2	7,052	5,324	65.3	32.6
Oregon	185.7	80.1	17.0	4,814	3,703	62.8	32.9
Pennsylvania:							
Public welfare	44.4	13.5	5.1	1,391	1,073	44.8	26.6
Vocational rehabilitation	1,220.6	561.3	97.7	31,104	24,261	68.4	52.7
Puerto Rico	83.9	45.4	6.6	2,790	2,077	50.4	47.7
Rhode Island	82.6	25.2	8.0	2,441	1,936	51.6	28.6
South Carolina:							
Public welfare	2.7	.1	.4	149	113	52.2	6.0
Vocational rehabilitation	360.5	153.8	28.8	9,180	7,172	57.0	32.9
South Dakota	37.7	13.8	3.8	1,374	1,097	38.0	21.4
Tennessee	356.4	187.7	29.2	12,447	9,742	57.5	38.4
Texas	861.1	399.4	77.6	21,898	15,820	47.6	20.2
Utah	44.5	15.0	4.5	1,252	1,056	47.3	26.8
Vermont	48.6	15.8	5.1	1,254	1,006	51.8	28.5
Virginia	264.6	150.3	21.5	8,354	6,086	50.5	34.5
Washington	241.1	101.4	19.9	6.520	5,170	61.0	27.4
West Virginia	453.0	207.9	39.1	11,831	8,754	55.8	33.0
Wisconsin:							
Public welfare	3.3	.8	.3	194	139	25.0	5.2
Vocational rehabilitation	299.4	101.5	29.4	7,762	6,241	44.2	21.1
Wyoming	22.5	3.6	2.6	730	589	51.0	3.4

TABLE 9.—*Selected data on State agency operations, fiscal year 1966*

State agencies	Expenditures (in thousands of dollars)		Average number of employees on disability work	Disability cases completed		Percent of all cases which require additional evidence	
	Total	Medical examinations		Total	Initial determination	Evidence of all types	Purchase medical evidence
United States	31,133.9	12,897.3	2,114.2	609,735	442,819	59.0	39.5
Alabama	813.4	443.4	41.2	14,854	10,425	64.4	47.3
Alaska	33.1	4.0	2.2	449	305	49.4	18.0
Arizona	282.2	109.3	21.0	5,726	4,092	58.7	40.1
Arkansas	425.5	181.9	26.6	8,559	6,239	74.0	53.0
California	3,722.3	1,359.2	241.9	56,243	41,099	58.0	34.4
Colorado	258.7	96.2	18.0	5,058	3,645	54.4	34.8
Connecticut	292.5	59.9	25.9	6,545	4,941	40.6	23.5
Delaware:							
Public welfare	1.6	0	.2	47	32	27.7	0
Vocational rehabilitation	61.6	10.4	6.6	1,446	1,091	40.6	19.4
District of Columbia	159.3	55.1	11.6	2,758	1,934	61.4	47.2
Florida	1,080.0	528.3	64.9	22,201	15,741	62.5	43.8
Georgia	1,095.9	509.7	56.5	18,152	12,963	67.4	53.4
Guam							
Hawaii	98.0	20.0	6.7	1,793	1,273	44.3	21.0
Idaho	112.0	47.5	6.9	1,797	1,303	56.8	38.5
Illinois	1,588.9	722.3	115.9	33,346	24,103	57.9	41.2
Indiana	725.5	405.3	48.4	14,100	10,016	64.3	39.8
Iowa	284.5	120.4	21.2	6,423	5,054	58.6	37.4
Kansas	277.0	108.7	17.6	5,642	4,234	58.0	35.7
Kentucky	644.1	290.7	47.7	13,246	8,535	59.0	49.4
Louisiana	872.9	378.8	49.5	13,107	9,791	66.0	53.5
Maine	91.0	24.3	9.0	2,556	1,924	42.8	22.0
Maryland	339.8	156.2	23.8	9,218	6,591	48.9	35.1
Massachusetts	788.4	289.4	59.7	13,621	10,311	66.0	41.5
Michigan	1,356.9	619.8	77.5	22,130	16,419	60.0	41.4
Minnesota	353.9	134.7	25.2	7,813	5,794	46.0	21.8
Mississippi	459.0	187.2	32.3	8,979	6,364	64.8	48.5
Missouri	749.5	308.7	44.8	13,737	10,181	53.7	39.2
Montana	109.0	37.1	7.4	1,908	1,400	49.2	35.1
Nebraska	151.7	40.5	13.4	3,715	2,764	42.6	21.1
Nevada	89.8	35.4	4.6	1,156	797	61.9	36.4
New Hampshire	76.3	20.6	6.5	1,557	1,223	47.6	30.4
New Jersey	843.5	346.5	63.8	18,586	13,839	56.1	42.3
New Mexico	158.7	61.9	9.7	2,962	2,218	57.5	34.1
New York	2,723.3	928.6	209.3	56,954	41,967	53.6	34.9
North Carolina	879.3	361.3	64.1	17,514	12,962	59.2	38.0
North Dakota	74.3	23.4	5.6	1,416	1,060	46.9	29.0
Ohio	1,286.4	537.9	90.6	26,829	20,012	65.8	41.1
Oklahoma	485.8	237.9	30.9	9,306	6,774	67.2	42.2
Oregon	260.8	105.9	17.7	6,302	4,555	58.3	31.7
Pennsylvania:							
Public welfare	45.9	9.2	4.8	1,036	743	52.0	33.6
Vocational rehabilitation	1,533.2	656.4	112.3	34,952	25,264	52.8	41.2
Puerto Rico	289.1	158.3	19.1	8,085	5,635	68.9	62.0
Rhode Island	129.5	38.6	10.0	2,525	1,935	56.6	35.7
South Carolina:							
Public welfare	2.9	.1	.4	136	80	34.6	8.1
Vocational rehabilitation	574.3	208.5	36.6	9,898	7,103	60.9	35.7
South Dakota	76.0	23.1	6.3	1,863	1,338	47.0	23.3
Tennessee	621.2	289.6	41.4	14,520	10,007	61.2	46.2
Texas	1,461.9	651.0	99.8	32,440	23,346	60.6	35.2
Utah	91.2	28.0	6.7	1,865	1,392	51.6	34.2
Vermont	53.1	17.9	4.4	1,266	948	47.2	29.4
Virginia	625.4	283.3	41.7	13,521	9,785	52.0	37.0
Washington	445.5	219.5	26.5	8,601	6,436	70.0	45.5
West Virginia	533.5	225.8	37.7	9,639	6,391	49.4	36.3
Wisconsin:							
Public welfare	3.2	.4	.3	196	138	30.6	10.2
Vocational rehabilitation	506.1	168.2	36.7	10,470	7,637	42.8	29.1
Wyoming	38.5	11.0	3.1	971	670	43.5	21.8

TABLE 10.—*Selected data on State agency operations, fiscal year 1967*

State agencies	Expenditures (in thousands of dollars)		Average number of employees on disability work	Disability cases completed		Percent of all cases which require additional evidence	
	Total	Medical examinations		Total	Initial determination	Evidence of all types	Purchase medical evidence
United States	35, 130. 1	15, 102. 4	2, 190. 8	693, 285	460, 630	60. 1	38. 7
Alabama	820. 6	424. 5	47. 2	15, 476	9, 753	64. 7	44. 9
Alaska	33. 9	7. 7	2. 1	456	324	48. 0	18. 2
Arizona	316. 4	133. 3	21. 4	6, 643	4, 278	65. 2	41. 2
Arkansas	464. 8	198. 8	27. 2	9, 772	6, 485	74. 5	49. 6
California	4, 531. 9	1, 962. 3	258. 4	77, 190	52, 187	59. 7	35. 5
Colorado	291. 4	112. 5	19. 6	6, 238	4, 149	53. 6	31. 3
Connecticut	278. 2	55. 2	25. 5	7, 354	4, 908	49. 4	20. 6
Delaware:							
Public welfare	2. 0	0	. 3	53	21	82. 8	9. 4
Vocational rehabilitation	69. 3	11. 8	6. 9	1, 754	1, 155	42. 7	16. 6
District of Columbia	166. 3	64. 4	12. 0	2, 858	1, 964	60. 3	43. 4
Florida	1, 378. 2	681. 5	72. 7	24, 516	16, 210	68. 2	45. 9
Georgia	1, 225. 5	591. 3	66. 6	19, 890	12, 673	65. 3	49. 1
Guam	-------	-------	-------	-------	-------	-------	-------
Hawaii	125. 0	28. 3	8. 7	1, 852	1, 207	56. 4	23. 6
Idaho	124. 4	54. 4	7. 2	2, 212	1, 386	53. 1	38. 2
Illinois	1, 563. 7	676. 3	104. 9	31, 692	20, 771	59. 4	38. 7
Indiana	767. 8	434. 2	46. 2	15, 092	9, 838	66. 1	39. 5
Iowa	337. 7	139. 3	22. 9	6, 840	4, 856	62. 1	38. 5
Kansas	303. 5	111. 7	18. 5	6, 221	4, 355	66. 4	36. 1
Kentucky	707. 1	322. 8	47. 2	13, 819	8, 395	59. 0	46. 2
Louisiana	972. 5	433. 0	53. 7	15, 256	10, 177	69. 0	54. 9
Maine	109. 9	35. 1	9. 6	3, 019	2, 129	60. 0	24. 4
Maryland	259. 3	218. 1	27. 4	10, 740	7, 450	52. 1	35. 8
Massachusetts	916. 5	349. 2	61. 0	15, 845	19, 997	65. 2	40. 8
Michigan	1, 606. 1	747. 3	81. 7	26, 029	18, 025	61. 6	41. 1
Minnesota	416. 8	136. 5	28. 3	9, 340	6, 271	50. 2	23. 1
Mississippi	559. 6	225. 4	35. 1	10, 465	6, 779	67. 7	49. 2
Missouri	848. 3	362. 8	46. 2	15, 852	10, 815	55. 8	39. 3
Montana	125. 8	52. 3	7. 3	2, 191	1, 474	52. 0	42. 6
Nebraska	182. 2	53. 3	14. 3	4, 469	2, 993	43. 2	18. 6
Nevada	102. 9	40. 9	5. 3	1, 476	928	57. 8	35. 5
New Hampshire	88. 9	18. 9	7. 1	1, 820	1, 293	44. 1	23. 2
New Jersey	1, 044. 2	444. 4	71. 8	19, 839	13, 539	66. 0	46. 3
New Mexico	197. 2	84. 4	10. 4	3, 172	2, 351	64. 2	35. 4
New York	3, 239. 1	1, 147. 6	217. 2	65, 239	44, 017	56. 2	35. 6
North Carolina	853. 3	373. 2	56. 6	19, 519	12, 838	53. 8	35. 7
North Dakota	83. 6	22. 9	6. 7	1, 669	1, 137	58. 5	27. 4
Ohio	1, 461. 0	610. 2	87. 7	30, 066	20, 705	68. 3	40. 9
Oklahoma	521. 9	277. 0	31. 6	10, 598	7, 216	68. 9	40. 9
Oregon	314. 5	118. 2	19. 7	7, 342	4, 803	67. 5	31. 7
Pennsylvania:							
Public welfare	55. 0	21. 4	4. 5	1, 316	975	55. 7	42. 1
Vocational rehabilitation	1, 586. 5	732. 0	102. 8	39, 197	25, 557	48. 9	39. 6
Puerto Rico	375. 8	233. 7	21. 7	8, 332	5, 458	69. 4	61. 0
Rhode Island	136. 0	39. 3	9. 8	2, 779	1, 912	54. 6	32. 3
South Carolina:							
Public welfare	1. 4	0	. 2	60	36	47. 6	6. 7
Vocational rehabilitation	599. 7	194. 7	37. 6	11, 443	7, 367	61. 2	30. 7
South Dakota	89. 8	28. 9	6. 5	2, 092	1, 370	52. 9	24. 5
Tennessee	733. 3	391. 3	40. 2	15, 616	10, 071	63. 9	46. 9
Texas	1, 569. 2	686. 7	105. 2	36, 064	23, 271	62. 7	33. 6
Utah	108. 2	33. 8	7. 3	2, 109	1, 464	53. 3	37. 9
Vermont	57. 4	22. 6	4. 1	1, 406	978	51. 3	32. 7
Virginia	674. 7	278. 4	49. 2	15, 944	10, 416	54. 0	33. 5
Washington	532. 8	262. 3	26. 6	9, 566	6, 350	69. 3	43. 1
West Virginia	572. 4	235. 4	39. 1	10, 391	6, 306	48. 4	31. 3
Wisconsin:							
Public welfare	3. 0	. 2	. 2	179	126	---------	7. 3
Vocational rehabilitation	586. 8	171. 9	38. 4	11, 370	7, 454	47. 4	27. 1
Wyoming	36. 8	8. 8	3. 2	1, 007	667	41. 7	21. 9

TABLE 11.—*Selected data on State agency operations, fiscal year 1968*

State agencies	Expenditures (in thousands of dollars)		Average number of employees on disability work	Disability cases completed		Percent of all cases which require additional evidence	
	Total	Medical examinations		Total	Initial determination	Evidence of all types	Purchase medical evidence
United States	40, 900. 9	17, 151. 4	2, 410. 9	775, 728	483, 825	58. 9	36. 6
Alabama	893. 8	452. 0	50. 5	18, 480	10, 482	58. 7	39. 1
Alaska	39. 4	7. 9	2. 2	516	330	52. 3	21. 1
Arizona	382. 4	158. 5	23. 0	7, 353	4, 333	59. 6	39. 9
Arkansas	556. 4	231. 0	30. 6	11, 414	6, 840	68. 9	44. 1
California	5, 360. 8	2, 310. 5	286. 2	89, 053	56, 116	58. 7	35. 0
Colorado	386. 0	141. 5	23. 4	7, 086	4, 240	56. 0	31. 3
Connecticut	355. 0	80. 3	27. 6	8, 208	5, 326	45. 5	23. 7
Delaware:							
Public welfare	2. 0	0	. 3	49	23	100. 0	4. 1
Vocational rehabilitation	73. 9	13. 3	6. 9	1, 851	1, 209	43. 8	16. 0
District of Columbia	182. 4	61. 5	12. 6	3, 337	2, 161	53. 3	37. 4
Florida	1, 462. 1	712. 3	79. 0	27, 563	16, 709	62. 0	39. 6
Georgia	1, 422. 6	706. 5	73. 7	21, 987	12, 948	63. 7	44. 8
Guam	1. 4	0	. 1	20	15	65. 0	25. 0
Hawaii	137. 9	32. 1	8. 7	2, 169	1, 302	56. 7	22. 6
Idaho	140. 3	50. 5	8. 2	2, 853	1, 671	49. 2	28. 8
Illinois	1, 677. 0	717. 8	102. 9	34, 023	21, 741	58. 1	36. 0
Indiana	830. 5	438. 5	46. 7	17, 666	11, 103	61. 4	34. 5
Iowa	389. 0	148. 4	25. 6	7, 645	5, 094	61. 5	35. 1
Kansas	373. 0	155. 9	20. 7	6, 743	4, 403	62. 8	32. 7
Kentucky	728. 7	301. 9	49. 2	15, 334	8, 735	54. 6	38. 5
Louisiana	1, 298. 5	683. 5	58. 1	17, 768	10, 432	71. 0	55. 9
Maine	131. 2	41. 9	10. 6	3, 192	2, 041	54. 6	26. 6
Maryland	575. 8	271. 8	35. 6	12, 548	8, 315	53. 4	37. 0
Massachusetts	1, 017. 1	367. 0	64. 6	17, 014	11, 288	66. 0	39. 8
Michigan	1, 853. 5	884. 6	85. 2	29, 517	19, 409	59. 5	38. 7
Minnesota	490. 2	146. 8	31. 5	10, 082	6, 333	51. 2	23. 8
Mississippi	627. 0	253. 5	39. 2	12, 197	6, 973	62. 4	43. 6
Missouri	940. 6	394. 7	51. 0	16, 888	10, 955	56. 8	36. 9
Montana	157. 4	65. 8	8. 5	2, 700	1, 703	55. 7	44. 3
Nebraska	200. 1	61. 6	15. 0	4, 749	3, 015	45. 7	19. 7
Nevada	123. 1	45. 2	6. 4	1, 689	971	56. 8	33. 6
New Hampshire	97. 7	22. 6	7. 3	2, 110	1, 418	41. 9	22. 8
New Jersey	1, 315. 5	522. 1	87. 6	23, 462	15, 460	63. 0	43. 3
New Mexico	252. 8	118. 2	12. 0	4, 132	2, 458	65. 0	38. 4
New York	3, 480. 6	1, 061. 5	237. 7	67, 140	43, 945	57. 0	33. 0
North Carolina	976. 2	423. 8	59. 7	21, 453	13, 238	53. 8	33. 6
North Dakota	91. 0	25. 9	7. 4	1, 789	1, 138	56. 2	27. 8
Ohio	1, 595. 9	630. 5	95. 7	33, 396	21, 229	66. 8	36. 6
Oklahoma	544. 5	256. 9	34. 0	12, 345	7, 469	67. 0	33. 9
Oregon	439. 9	176. 6	27. 2	8, 589	5, 258	67. 5	33. 9
Pennsylvania:							
Public welfare	70. 3	34. 9	4. 5	1, 567	1, 020	48. 9	37. 7
Vocational rehabilitation	1, 937. 8	915. 9	117. 0	43, 078	26, 783	49. 6	40. 4
Puerto Rico	484. 9	298. 0	27. 5	10, 776	7, 024	67. 3	60. 3
Rhode Island	170. 8	50. 1	10. 5	3, 118	2, 109	55. 6	35. 1
South Carolina:							
Public welfare	4. 0	0	. 6	114	72	47. 4	12. 3
Vocational rehabilitation	690. 9	216. 2	40. 7	12, 817	7, 619	61. 9	29. 5
South Dakota	110. 9	33. 5	7. 6	2, 411	1, 487	51. 0	22. 4
Tennessee	743. 5	371. 7	41. 1	17, 973	10, 556	55. 5	38. 7
Texas	2, 048. 8	867. 6	121. 2	39, 050	23, 127	62. 4	33. 2
Utah	129. 5	45. 7	8. 2	2, 241	1, 424	61. 8	44. 1
Vermont	68. 7	24. 1	5. 0	1, 593	1, 052	58. 1	32. 1
Virginia	845. 3	362. 2	55. 8	17, 938	10, 963	55. 8	36. 2
Washington	681. 9	338. 3	31. 2	11, 384	7, 231	69. 6	42. 5
West Virginia	631. 6	252. 2	41. 3	11, 637	6, 346	45. 6	30. 0
Wisconsin:							
Public welfare	----	----	----	----	----	----	----
Vocational rehabilitation	628. 6	153. 2	42. 6	12, 714	8, 399	47. 3	19. 5
Wyoming	50. 2	12. 9	3. 7	1, 207	784	40. 0	22. 0

TABLE 12.—*Selected data on State agency operations, fiscal year 1969*

State agencies	Expenditures (in thousands of dollars)		Average number of employees on disability work	Disability cases completed		Percent of all cases which require additional evidence	
	Total	Medical examinations		Total	Initial determination	Evidence of all types	Purchase medical evidence
United States	48, 142. 7	20. 226. 3	2, 710. 0	934, 284	548, 099	59. 2	34. 5
Alabama	1, 103. 1	583. 6	51. 9	22, 874	12, 518	57. 4	36. 1
Alaska	62. 5	16. 9	2. 7	719	435	44. 5	23. 9
Arizona	425. 4	181. 3	24. 9	8, 314	4, 660	60. 6	38. 6
Arkansas	575. 0	236. 0	34. 1	13. 124	7, 353	66. 8	38. 8
California	6, 335. 8	2, 666. 1	307. 1	108, 775	63, 401	49. 8	28. 3
Colorado	469. 6	171. 4	28. 7	9, 195	5, 185	49. 6	24. 7
Connecticut	458. 4	140. 0	31. 6	9, 969	6, 176	50. 8	27. 2
Delaware:							
Public welfare	2. 6	0	. 3	79	35	87. 3	2. 5
Vocational rehabilitation	96. 0	19. 3	6. 9	2, 224	1, 328	51. 8	18. 9
District of Columbia	237. 3	94. 1	13. 0	4, 130	2, 424	54. 0	37. 3
Florida	1, 752. 0	876. 9	102. 1	32. 063	18. 941	62. 3	37. 6
Georgia	1, 537. 7	746. 5	72. 4	26, 949	15, 022	66. 7	40. 0
Guam	3. 7	. 2	. 4	62	47	65. 1	13. 2
Hawaii	168. 3	45. 7	10. 2	2, 810	1, 637	56. 4	23. 3
Idaho	167. 5	56. 8	10. 1	3, 534	1, 879	40. 3	22. 1
Illinois	2, 037. 5	911. 9	119. 7	43, 473	25, 717	58. 7	35. 0
Indiana	957. 9	500. 3	54. 3	22, 365	13, 640	61. 5	30. 9
Iowa	478. 2	166. 7	30. 6	8, 564	5, 537	62. 6	32. 6
Kansas	413. 6	167. 1	22. 2	7, 804	4, 959	56. 6	29. 6
Kentucky	877. 7	406. 1	53. 0	17, 737	9, 491	54. 7	39. 2
Louisiana	1, 343. 6	692. 0	64. 8	21, 140	11, 889	68. 4	51. 2
Maine	162. 2	57. 9	11. 3	3, 975	2, 475	50. 8	23. 9
Maryland	759. 4	385. 7	41. 3	16, 399	9, 908	54. 3	36. 2
Massachusetts	1, 116. 1	439. 5	70. 2	19, 907	12, 239	67. 8	38. 9
Michigan	2, 219. 1	933. 1	106. 6	39, 185	24, 683	53. 0	31. 2
Minnesota	585. 5	170. 0	34. 3	10, 996	6, 419	55. 8	25. 6
Mississippi	672. 0	239. 9	41. 1	14, 616	7, 950	54. 7	35. 0
Missouri	1, 135. 0	459. 7	55. 4	19, 870	12, 056	57. 1	32. 8
Montana	188. 1	84. 4	9. 2	3, 272	1, 967	51. 8	39. 0
Nebraska	222. 7	75. 5	16. 2	5, 475	3, 203	45. 2	19. 5
Nevada	120. 6	44. 7	6. 1	2, 226	1, 236	51. 6	27. 6
New Hampshire	118. 2	27. 1	8. 7	2, 349	1, 603	54. 5	21. 1
New Jersey	1, 576. 5	624. 0	100. 4	26, 974	16, 502	62. 6	37. 7
New Mexico	302. 8	137. 0	14. 9	4, 972	2, 733	66. 4	38. 8
New York	4, 429. 1	1, 403. 0	274. 6	79, 765	48, 311	59. 1	31. 1
North Carolina	1, 037. 3	424. 3	63. 8	24, 868	14, 483	57. 6	31. 2
North Dakota	102. 9	24. 3	8. 9	2, 314	1, 308	54. 4	19. 9
Ohio	1, 684. 7	626. 2	103. 2	42, 375	25, 133	66. 2	29. 6
Oklahoma	669. 1	333. 9	40. 0	13, 251	7, 550	68. 5	35. 4
Oregon	530. 9	219. 0	30. 6	10, 487	6, 165	63. 4	32. 0
Pennsylvania:							
Public welfare	92. 0	51. 7	4. 9	2, 060	1, 343	56. 6	46. 2
Vocational rehabilitation	2, 524. 8	1, 302. 9	140. 7	49, 667	28, 706	59. 4	47. 6
Puerto Rico	621. 5	385. 2	31. 7	16, 362	9, 556	66. 5	59. 1
Rhode Island	184. 8	61. 4	11. 0	3, 829	2, 422	57. 2	36. 3
South Carolina:							
Public welfare	4. 2	0	. 5	112	67	0	0
Vocational rehabilitation	764. 6	223. 9	46. 7	14, 839	8, 159	64. 6	27. 1
South Dakota	117. 3	27. 3	8. 7	2, 523	1, 423	54. 5	20. 5
Tennessee	885. 2	458. 7	45. 7	21, 320	12, 183	59. 2	40. 5
Texas	2, 216. 4	840. 5	136. 8	45, 436	26, 153	62. 6	30. 0
Utah	164. 3	56. 6	8. 9	2, 834	1, 707	64. 4	44. 0
Vermont	76. 2	26. 7	5. 6	1, 839	1, 119	52. 0	28. 5
Virginia	1, 010. 8	446. 6	63. 8	20, 623	11, 859	57. 9	39. 0
Washington	766. 2	366. 9	35. 5	13, 962	8, 542	67. 7	37. 4
West Virginia	759. 0	363. 2	42. 0	13, 473	6, 763	47. 7	32. 6
Wisconsin:							
Public welfare							
Vocational rehabilitation	764. 9	214. 9	45. 5	14, 961	9, 177	49. 0	22. 0
Wyoming	54. 9	11. 7	4. 2	1, 264	749	38. 0	17. 9

TABLE 13.—*Selected data on State agency operations, fiscal year 1970*

State agencies	Expenditures (in thousands of dollars)		Average number of employees on disability work [1]	Disability cases completed		Percent of all cases which require additional evidence	
	Total	Medical examinations		Total	Initial determination	Evidence of all types	Purchase medical evidence
United States	45,002.0	14,872.5	2,710.5	929,995	623,515	58.1	26.0
Alabama	861.9	365.9	48.6	21,265	13,646	51.6	27.3
Alaska	57.6	8.8	3.1	610	439	44.1	16.4
Arizona	390.1	139.4	24.5	7,676	4,946	57.6	30.2
Arkansas	549.0	198.8	34.0	13,266	8,622	66.3	30.6
California	5,187.5	1,415.2	294.6	108,857	69,699	51.2	19.8
Colorado	472.0	153.4	29.0	8,626	5,631	51.1	24.1
Connecticut	449.0	106.0	33.2	10,607	7,119	54.2	23.6
Delaware:							
Public welfare	2.6	0	.3	79	26	100.0	1.3
Vocational rehabilitation	106.0	20.4	8.1	2,097	1,451	57.2	18.4
District of Columbia	271.4	104.6	13.1	4,472	3,186	54.1	35.9
Florida	1,576.4	581.6	98.6	31,910	21,075	63.4	27.6
Georgia	257.3	509.1	67.1	26,680	17,233	63.0	28.5
Guam	3.0	.4	.1	88	58	21.6	17.0
Hawaii	165.8	30.0	10.4	2,568	1,733	58.7	18.9
Idaho	164.5	54.5	9.7	3,399	2,051	46.2	22.8
Illinois	1,964.6	668.0	123.3	42,570	29,534	57.8	26.3
Indiana	918.7	442.3	55.7	22,947	15,423	61.3	24.9
Iowa	483.3	164.6	31.2	9,096	6,434	64.8	30.2
Kansas	407.2	136.5	22.4	7,744	5,440	59.5	26.3
Kentucky	828.6	355.3	51.0	16,658	10,680	54.9	32.5
Louisiana	1,262.7	543.6	64.0	21,503	14,015	66.8	42.0
Maine	197.0	74.1	12.6	4,533	3,094	48.4	26.2
Maryland	775.0	353.2	41.0	15,883	10,732	54.6	33.3
Massachusetts	1,212.2	404.3	72.2	19,694	13,814	69.5	32.8
Michigan	2,301.6	937.4	115.2	42,158	29,080	53.7	24.9
Minnesota	599.2	146.6	35.4	10,833	7,207	57.3	23.9
Mississippi	645.0	220.6	41.1	14,708	9,409	53.2	27.1
Missouri	1,044.6	340.2	60.6	20,742	14,320	54.2	26.7
Montana	161.4	55.8	9.8	3,475	2,218	41.5	23.8
Nebraska	202.3	51.7	15.7	5,248	3,368	45.3	16.7
Nevada	123.5	36.6	6.9	2,305	1,336	49.7	16.9
New Hampshire	118.6	30.3	8.2	2,954	1,989	51.1	18.4
New Jersey	1,518.0	465.2	97.9	27,693	19,430	60.7	26.7
New Mexico	305.9	107.1	15.2	4,757	3,013	68.0	33.2
New York	4,116.0	576.4	276.4	77,407	55,387	58.4	14.9
North Carolina	951.4	298.9	63.6	24,325	16,777	55.9	26.8
North Dakota	102.5	17.4	9.0	2,201	1,379	56.0	16.7
Ohio	1,681.2	461.6	107.0	39,863	27,699	62.6	22.0
Oklahoma	552.9	177.1	39.4	14,019	9,209	61.8	20.8
Oregon	494.5	144.2	30.8	10,240	6,610	62.5	23.8
Pennsylvania:							
Public welfare							
Vocational rehabilitation	2,381.5	1,070.7	133.5	47,154	32,220	60.4	40.8
Puerto Rico	658.3	383.1	37.4	17,939	10,780	66.5	56.1
Rhode Island	196.5	52.6	11.7	3,782	2,599	54.7	28.9
South Carolina:							
Public welfare	6.0	.1	.8	179	106	24.0	10.6
Vocational rehabilitation	777.8	180.7	48.2	15,005	9,774	68.0	21.7
South Dakota	115.1	19.2	8.5	2,512	1,645	58.2	16.2
Tennessee	833.9	357.9	46.9	20,990	14,114	62.7	26.4
Texas	2,058.3	626.6	141.8	46,472	30,503	59.6	19.8
Utah	162.7	48.4	9.0	2,746	1,858	63.7	37.7
Vermont	72.3	16.9	6.3	1,968	1,345	50.8	19.3
Virginia	946.6	350.1	60.6	20,230	13,758	55.6	30.0
Washington	640.5	232.6	35.0	14,216	9,891	63.9	24.3
West Virginia	755.3	371.3	39.0	12,512	7,685	53.9	34.3
Wisconsin:							
Public welfare							
Vocational rehabilitation	861.3	255.2	47.7	17,174	11,809	52.7	22.6
Wyoming	53.9	10.0	4.1	1,351	916	51.1	15.8

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[1] Includes black lung.

TABLE 14.—*Selected data on State agency operations, fiscal year 1971*

State agencies	Obligations (in thousands of dollars)		Average number of employees on disability work [1]	Disability cases completed		Percent of all cases which require additional evidence	
	Total	Medical examinations		Total	Initial determination	Evidence of all types	Purchase medical evidence
United States	62, 959. 0	23, 500. 7	3, 224. 7	1, 103, 734	779, 090	NA	27. 8
Alabama	1, 514. 3	770. 9	65. 8	25, 826	17, 920	----------	31. 6
Alaska	72. 4	12. 2	3. 3	785	527	----------	13. 2
Arizona	560. 7	203. 2	31. 6	10, 374	7, 308	----------	29. 7
Arkansas	705. 7	255. 0	41. 9	16, 433	11, 228	----------	27. 0
California	6, 953. 7	1, 996. 3	329. 3	128, 806	86, 958	----------	21. 2
Colorado	622. 0	241. 8	30. 6	10, 138	6, 940	----------	27. 1
Connecticut	616. 7	134. 0	36. 5	11, 570	8, 224	----------	25. 1
Delaware:							
Public welfare	1. 0	----------	. 2	26	18	----------	----------
Vocational rehabilitation	168. 1	34. 6	10. 0	2, 656	1, 967	----------	19. 3
District of Columbia	311. 3	129. 8	15. 3	4, 907	3, 594	----------	40. 5
Florida	1, 924. 7	780. 0	110. 8	37, 219	26, 182	----------	26. 6
Georgia	1, 581. 2	709. 4	73. 4	32, 544	21, 997	----------	28. 4
Guam	8. 3	. 2	. 3	37	23	----------	27. 0
Hawaii	206. 8	39. 2	10. 8	2, 879	2, 050	----------	19. 8
Idaho	214. 4	63. 8	11. 8	4, 020	2, 689	----------	22. 5
Illinois	2, 851. 2	1, 061. 1	155. 1	48, 461	35, 641	----------	25. 3
Indiana	1, 329. 2	650. 8	73. 2	26, 392	18, 888	----------	28. 2
Iowa	605. 1	236. 0	32. 7	10, 142	7, 565	----------	33. 2
Kansas	489. 2	194. 1	23. 8	9, 037	6, 523	----------	25. 6
Kentucky	1, 815. 9	1, 028. 5	70. 5	20, 486	13, 719	----------	37. 9
Louisiana	1, 536. 0	684. 8	66. 7	24, 786	16, 740	----------	45. 4
Maine	240. 0	88. 0	15. 1	5, 682	4, 063	----------	25. 0
Maryland	938. 4	410. 9	44. 9	17, 074	12, 174	----------	34. 5
Massachusetts	1, 394. 7	514. 1	69. 5	22, 964	16, 993	----------	33. 5
Michigan	2, 980. 3	1, 132. 3	137. 7	51, 730	36, 851	----------	27. 6
Minnesota	720. 6	190. 0	42. 1	13, 073	9, 465	----------	24. 2
Mississippi	844. 1	308. 6	49. 6	17, 767	11, 841	----------	28. 4
Missouri	1, 310. 4	430. 7	70. 2	25, 434	18, 581	----------	25. 5
Montana	207. 6	72. 7	12. 2	3, 940	2, 628	----------	27. 7
Nebraska	256. 4	63. 8	18. 8	5, 792	4, 022	----------	20. 3
Nevada	192. 9	68. 0	9. 1	2, 971	2, 022	----------	22. 7
New Hampshire	149. 8	41. 9	9. 4	3, 537	2, 505	----------	21. 0
New Jersey	1, 925. 6	546. 8	119. 9	34, 409	25, 417	----------	27. 9
New Mexico	428. 4	169. 9	19. 2	6, 464	4, 435	----------	33. 2
New York	5, 587. 9	936. 7	318. 5	88, 375	64, 103	----------	17. 1
North Carolina	1, 271. 6	434. 9	80. 4	30, 897	22, 101	----------	23. 3
North Dakota	121. 6	23. 2	9. 3	2, 212	1, 528	----------	19. 6
Ohio	2, 732. 7	928. 8	150. 8	49, 775	36, 084	----------	21. 8
Oklahoma	805. 1	307. 9	46. 2	15, 125	10, 360	----------	28. 0
Oregon	712. 7	255. 2	38. 2	13, 202	9, 081	----------	29. 1
Pennsylvania:							
Public welfare	----------	----------	----------	----------	----------	----------	----------
Vocational rehabilitation	3, 850. 9	2, 282. 2	149. 7	55, 135	40, 251	----------	48. 1
Puerto Rico	1, 060. 6	651. 2	58. 3	19, 766	12, 181	----------	61. 8
Rhode Island	235. 1	69. 0	13. 7	4, 522	3, 242	----------	33. 1
South Carolina:							
Public welfare	7. 1	. 4	. 9	238	154	----------	10. 1
Vocational rehabilitation	979. 2	263. 7	58. 9	19, 292	13, 282	----------	21. 7
South Dakota	137. 9	27. 0	9. 3	2, 901	2, 020	----------	19. 2
Tennessee	1, 271. 6	671. 1	56. 2	25, 521	17, 942	----------	29. 3
Texas	2, 730. 4	885. 3	158. 7	56, 640	38, 915	----------	22. 5
Utah	220. 7	72. 9	10. 8	3, 418	2, 400	----------	31. 0
Vermont	83. 8	16. 8	6. 5	2, 363	1, 707	----------	14. 9
Virginia	1, 458. 4	630. 9	69. 1	23, 375	16, 473	----------	31. 7
Washington	995. 5	388. 5	38. 4	17, 971	13, 037	----------	28. 3
West Virginia	1, 841. 2	1, 049. 6	79. 0	14, 115	9, 532	----------	39. 2
Wisconsin:							
Public welfare	----------	----------	----------	----------	----------	----------	----------
Vocational rehabilitation	1, 101. 5	316. 5	55. 4	19, 033	13, 977	----------	21. 3
Wyoming	76. 4	25. 5	5. 1	1, 497	1, 022	----------	17. 2

[1] Includes black lung.

NA—Not available.

TABLE 15.—*Selected data on State agency operations, fiscal year 1972*

State agencies	Obligations (in thousands of dollars)		Average number of employees on disability work [1]	Disability cases completed		Percent of all cases which require additional evidence	
	Total	Medical examinations		Total	Initial determination	Evidence of all types	Purchase medical evidence
United States	71,782.6	21,469.6	4,087.1	1,248,448	877,607	NA	23.7
Alabama	1,469.5	617.2	79.6	27,986	18,864	----------	27.7
Alaska	92.9	15.6	4.5	1,022	751	----------	13.0
Arizona	659.2	217.2	36.2	11,253	7,728	----------	26.9
Arkansas	756.7	231.8	48.9	17,623	11,731	----------	23.5
California	8,569.1	1,833.1	498.3	139,894	96,529	----------	18.6
Colorado	709.8	264.1	35.1	10,785	7,322	----------	28.1
Connecticut	786.9	178.9	49.6	15,167	11,252	----------	22.4
Delaware:							
Public welfare	----------	----------	----------	----------	----------	----------	----------
Vocational rehabilitation	240.2	57.4	12.1	3,076	2,266	----------	23.3
District of Columbia	422.5	142.8	22.3	5,697	4,249	----------	29.8
Florida	2,100.3	668.9	128.7	44,419	31,381	----------	19.6
Georgia	1,757.7	679.3	91.1	35,305	24,135	----------	25.1
Guam	8.8	.4	.5	71	0	----------	12.7
Hawaii	244.2	36.8	13.1	3,389	2,316	----------	18.2
Idaho	278.1	68.4	16.6	4,626	3,104	----------	25.8
Illinois	3,325.3	878.1	217.9	58,256	42,067	----------	21.7
Indiana	1,308.4	358.4	96.9	31,244	21,575	----------	15.8
Iowa	651.7	214.8	38.6	11,985	8,852	----------	27.3
Kansas	540.3	166.3	30.1	9,785	7,033	----------	21.2
Kentucky	1,672.6	711.3	92.3	22,924	15,286	----------	32.8
Louisiana	1,428.6	437.4	84.9	27,624	18,402	----------	27.5
Maine	273.8	67.8	19.5	6,208	4,308	----------	19.7
Maryland	1,040.6	374.1	56.1	19,438	14,147	----------	28.9
Massachusetts	1,918.6	503.2	98.4	26,850	19,520	----------	29.4
Michigan	3,806.2	1,295.2	176.2	56,746	40,176	----------	25.9
Minnesota	861.3	193.4	55.0	15,573	11,190	----------	21.6
Mississippi	903.1	291.7	55.1	17,972	11,779	----------	24.7
Missouri	1,479.2	465.4	79.4	27,405	19,870	----------	23.3
Montana	213.7	53.4	14.9	4,189	2,816	----------	18.2
Nebraska	313.7	77.2	20.7	6,544	4,524	----------	20.2
Nevada	219.1	47.0	13.0	3,694	2,410	----------	12.9
New Hampshire	160.6	39.3	10.5	3,726	2,600	----------	20.7
New Jersey	2,082.1	602.6	135.8	38,388	27,856	----------	23.4
New Mexico	447.1	128.7	22.5	6,987	4,603	----------	26.0
New York	6,744.1	886.1	368.7	98,408	72,199	----------	13.8
North Carolina	1,329.6	396.4	89.2	34,538	23,899	----------	18.0
North Dakota	136.9	26.7	10.2	2,470	1,715	----------	21.1
Ohio	3,046.6	941.0	165.5	59,601	43,155	----------	18.5
Oklahoma	833.6	291.0	52.8	16,060	11,014	----------	26.7
Oregon	835.9	247.4	49.0	15,943	11,035	----------	24.4
Pennsylvania:							
Public welfare	----------	----------	----------	----------	----------	----------	----------
Vocational rehabilitation	4,424.8	2,238.3	198.8	65,375	47,958	----------	43.5
Puerto Rico	1,356.0	520.2	99.5	22,712	13,827	----------	54.0
Rhode Island	281.3	72.7	16.1	5,047	3,535	----------	29.6
South Carolina:							
Public welfare	8.5	.6	1.3	200	146	----------	11.5
Vocational rehabilitation	1,048.9	261.0	62.3	19,888	13,276	----------	19.5
South Dakota	152.6	32.9	9.9	2,949	1,973	----------	21.2
Tennessee	1,270.4	514.2	72.3	30,365	21,141	----------	21.4
Texas	3,199.3	885.4	190.7	64,330	45,144	----------	20.3
Utah	245.5	72.1	12.4	4,124	2,860	----------	28.1
Vermont	100.0	17.4	8.1	2,643	1,913	----------	14.1
Virginia	1,643.7	589.5	96.9	27,720	19,498	----------	29.9
Washington	1,277.5	407.0	58.6	20,928	15,178	----------	24.9
West Virginia	1,760.5	852.0	92.3	16,228	11,002	----------	34.2
Wisconsin:							
Public welfare	----------	----------	----------	----------	----------	----------	----------
Vocational rehabilitation	1,267.7	286.3	71.6	21,322	15,283	----------	17.2
Wyoming	76.8	14.2	6.5	1,701	1,214	----------	13.1

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[1] Includes black lung.

NA—Not available.

Table 16.—*Selected data on State agency operations, fiscal year 1973*

State agencies	Obligations (in thousands of dollars)		Average number of employees on disability work [1]	Disability cases completed		Percent of all cases which require purchase medical evidence
	Total	Medical examinations		Total	Initial determination	
United States	92, 032. 0	24, 885. 1	4, 711. 0	1, 289. 227	932, 271	20. 9
Alabama	2, 158. 3	730. 8	100. 7	29, 500	20. 452	20. 2
Alaska	125. 0	24. 5	4. 3	1, 196	836	16. 6
Arizona	719. 6	201. 2	38. 6	11, 358	8, 077	19. 9
Arkansas	844. 4	230. 8	53. 0	17, 944	12, 290	18 2
California	10, 474. 5	1, 629. 5	578. 5	146, 501	102, 592	15. 3
Colorado	902. 5	286. 7	46. 3	10, 412	7, 439	24. 9
Connecticut	1, 047. 8	213. 1	57. 1	14, 662	11, 117	25. 4
Delaware:						
Public welfare						
Vocational rehabilitation	312. 9	66. 2	17. 9	3, 267	2, 426	24. 8
District of Columbia	470. 9	138. 8	24. 7	6, 044	4, 325	26. 4
Florida	3, 041. 9	801. 6	173. 1	46, 607	33, 084	19. 2
Georgia	2, 294. 3	666. 6	180. 9	34, 034	24, 219	20. 1
Guam	5. 4	. 6	. 2	59	33	23. 7
Hawaii	280. 9	36. 3	16. 0	3, 341	2, 306	15. 0
Idaho	373. 4	86. 9	19. 9	4, 640	3, 193	21. 3
Illinois	3, 706. 0	926. 7	189. 6	59, 072	43, 930	13. 9
Indiana	1, 957. 7	604. 8	125. 5	31, 105	21, 793	15. 6
Iowa	771. 3	256. 7	44. 4	12, 182	9, 163	24. 8
Kansas	728. 0	180. 0	33. 8	9, 574	7, 074	21. 0
Kentucky	2, 530. 8	1, 252. 0	105. 9	27, 357	18, 988	26. 0
Louisiana	1, 718. 8	476. 6	91. 5	28, 684	19, 823	27. 5
Maine	350. 5	80. 3	22. 4	6, 472	4, 556	20. 1
Maryland	1, 368. 2	455. 7	71. 3	20, 777	15, 198	27. 9
Massachusetts	2, 019. 4	394. 3	113. 3	27, 770	20, 706	18. 8
Michigan	4, 635. 7	1, 246. 1	199. 1	57, 180	41, 722	18. 0
Minnesota	1, 242. 2	234. 1	64. 3	15, 620	11, 372	19. 1
Mississippi	1, 091. 8	258. 0	64. 1	18, 604	12, 454	20. 4
Missouri	1, 665. 1	465. 2	82. 9	27, 260	20, 604	21. 7
Montana	284. 7	84. 5	14. 7	4, 426	3, 105	20. 2
Nebraska	379. 4	84. 4	23. 7	6, 522	4, 595	21. 1
Nevada	273. 5	47. 4	14. 2	3, 605	2, 335	11. 7
New Hamsphire	190. 0	38. 2	11. 7	4, 080	2, 872	15. 1
New Jersey	2, 948. 7	740. 5	158. 3	39, 794	29, 696	23. 3
New Mexico	520. 3	172. 7	23. 9	6, 690	4, 482	23. 8
New York	8, 457. 4	1, 304. 8	420. 7	104, 565	80, 291	18. 0
North Carolina	1, 958. 3	440. 6	110. 3	35, 763	26, 296	18. 5
North Dakota	135. 3	25. 0	9. 0	2, 460	1, 802	16. 8
Ohio	4, 047. 4	1, 288. 6	193. 1	59, 259	45, 029	13. 6
Oklahoma	978. 1	308. 2	52. 6	15, 997	11, 309	24. 3
Oregon	1, 084. 3	320. 4	50. 1	15, 574	11, 021	27. 4
Pennsylvania:						
Public welfare						
Vocational rehabilitation	6, 040. 4	2, 434. 6	266. 6	73, 763	56, 894	34. 9
Puerto Rico	1, 984. 9	810. 6	107. 5	23, 981	15, 118	55. 4
Rhode Island	356. 5	70. 2	18. 6	5, 625	4, 009	24. 7
South Carolina:						
Public welfare	7. 7	. 3	1. 0	204	158	13. 7
Vocational rehabilitation	1, 388. 7	266. 5	73. 0	20, 439	14, 238	19. 4
South Dakota	171. 0	37. 8	8. 7	2, 812	1, 948	23. 3
Tennessee	1, 760. 0	660. 5	88. 8	29, 648	20, 437	19. 1
Texas	4, 157. 6	1, 128. 3	221. 9	64, 773	46, 328	20. 6
Utah	343. 2	104. 0	14. 6	4, 395	3, 109	27. 2
Vermont	112. 5	13. 0	9. 0	2, 836	2, 019	8. 8
Virginia	2, 286. 9	763. 8	122. 1	29, 038	20, 424	20. 6
Washington	1, 523. 3	528. 1	64. 6	20, 835	15, 505	22. 3
West Virginia	2, 204. 9	958. 1	101. 8	17, 908	12, 493	30. 5
Wisconsin:						
Public welfare						
Vocational rehabilitation	1, 493. 8	282. 9	76. 8	21, 400	15, 771	15. 5
Wyoming	105. 9	27. 0	6. 4	1, 613	1, 155	13. 0

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[1] Includes black lung. No administrative positions.

B. Workload and Processing Time

1. WORKLOAD

Table 17 shows current pending workload in the State Agency and the District Office for each type of disability application as of stated date. Table 18 shows actual and projected receipts of Social Security and Supplemental Security Income disability claims in the State Agency. Tables 19 and 20 show the pending backlog of disability cases in three State Agencies and nationally in early June 1974.

TABLE 17.—*Workload in State agency and district office*

	State agencies				District offices		
Week ending—	Social security only [1]	Supplemental security income, new [2]	Supplemental security income and aid to permanently and totally disabled, post-June [3]	Social security and supplemental security income [4]	Social security only [1]	Supplemental security income, new [2]	Social security and supplemental security income [4]
Feb. 13, 1974	181, 058	98, 480	16, 636	296, 174	93, 193	146, 597	239, 790
Feb. 20, 1974	185, 436	117, 114	20, 959	323, 509	96, 557	146, 300	242, 857
Feb. 27, 1974	191, 044	144, 895	35, 533	371, 472	97, 504	142, 925	240, 429
Mar. 6, 1974	199, 532	173, 032	35, 400	407, 964	96, 520	142, 809	239, 329
Mar. 13, 1974	205, 498	185, 845	33, 483	424, 826	95, 219	142, 006	237, 225
Mar. 20, 1974	209,445	172,451	31,744	413,650	94,501	138,792	233,293
Mar. 27, 1974	213,047	181,471	32,963	427,481	93,989	134,923	228,912
Apr. 3, 1974	214,933	184,932	31,846	431,711	93,641	132,951	226,592
Apr. 10, 1974	216,228	185,696	30,522	432,446	92,692	130,539	223,231
Apr. 17, 1974 [5]	218,355	184,284	35,099	437,738	91,789	128,115	219,904
Apr. 24, 1974	218,276	184,310	32,818	435,404	91,082	124,488	215,570
May 1, 1974	219,980	187,604	32,368	439,952	90,122	120,687	210,809
May 8, 1974	217,757	187,342	30,313	435,412	88,077	116,732	204,809
May 15, 1974	216,689	185,504	27,507	429,700	87,737	113,778	201,515
May 22, 1974	212,531	184,920	25,725	423,176	85,475	110,034	195,509
May 29, 1974	211,198	177,602	26,179	414,979	86,349	109,638	195,987

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[1] Title II disabled worker applications only.

[2] Supplemental security income new applicant.

[3] Welfare APTD cases who came on rolls after June 1973.

[4] Includes social security only, supplemental security income only, and social security and supplemental security income.

[5] Includes child and disabled widow applications from Apr. 17 on.

TABLE 18.—*State agency workload realization report, week ending Apr. 17, 1974*

State agency	Disability insurance case receipts			Supplemental security income case receipts			Total projected receipts	Total actual receipts	Percent difference
	Projected	Actual	Percent realized	Projected	Actual	Percent realized			
United States	1, 147, 073. 8	1, 172, 443	102. 2	526, 845. 9	512, 388	97. 3	1, 673, 919. 7	1, 684, 831	0. 7
Connecticut	13, 016. 0	14, 099	108. 3	7, 821. 5	3, 402	43. 5	20, 837. 5	17, 501	−16. 0
Maine	5, 601. 4	6, 331	113. 0	3, 290. 0	1, 775	54. 0	8, 891. 3	8, 106	−8. 8
Massachusetts	24, 797. 7	26, 779	108. 0	10, 552. 1	9, 249	87. 7	35, 349. 7	36, 028	1. 9
New Hampshire	3, 624. 5	3, 902	107. 7	2, 606. 8	785	30. 1	6, 231. 4	4, 687	−24. 8
Rhode Island	4, 859. 8	5, 156	106. 1	5, 585. 9	2, 783	49. 8	10, 445. 8	7, 939	−24. 0
Vermont	2, 470. 5	2, 687	108. 8	993. 0	962	96. 9	3, 463. 6	3, 649	5. 4
New Jersey	35, 590. 0	35, 229	99. 0	18, 249. 8	13, 121	71. 9	53, 839. 8	48, 350	−10. 2
New York	93, 917. 5	91, 395	97. 3	26, 071. 3	57, 200	219. 4	119, 988. 8	148, 595	23. 8
Puerto Rico	21, 172. 1	21, 961	103. 7	0	0	0	21, 172. 1	21, 961	3. 7
Delaware	2, 965. 2	2, 810	94. 8	744. 5	818	109. 9	3, 709. 8	3, 628	−2. 2
District of Columbia	5, 601. 4	4, 870	86. 9	1, 489. 0	1, 927	129. 4	7, 090. 4	6, 797	−4. 1
Maryland	18, 371. 5	19, 056	103. 7	15, 270. 7	8, 647	56. 6	33, 642. 2	27, 703	−17. 7
Pennsylvania	62, 199. 9	67, 338	108. 3	57, 855. 3	26, 190	45. 3	120, 055. 2	93, 528	−22. 1
Virginia	25, 703. 8	27, 865	107. 9	21, 664. 6	10, 074	46. 5	47, 168. 1	37, 629	−20. 6
West Virginia	16, 322. 9	16, 478	107. 5	9, 124. 4	5, 158	56. 5	24, 447. 3	21, 636	−11. 5
Alabama	25, 703. 8	27, 182	105. 8	21, 539. 8	14, 897	69. 2	47, 243. 6	42, 079	−10. 9
Florida	41, 026. 7	42, 275	103. 0	26, 568. 3	21, 292	80. 1	67, 595. 1	63, 567	−6. 0
Georgia	31, 305. 2	34, 385	109. 8	13, 222. 3	17, 363	131. 3	44, 527. 4	51, 748	16. 2
Kentucky	22, 655. 3	23, 383	103. 2	4, 158. 3	9, 992	240. 3	26, 813. 5	33, 375	24. 5
Mississippi	16, 641. 5	19, 723	118. 5	15, 829. 1	12, 194	77. 0	32, 470. 6	31, 917	−1. 7
North Carolina	30, 976. 0	32, 687	105. 5	34, 079. 9	16, 930	49. 7	65, 055. 9	49, 617	−23. 7

South Carolina:									
Vocational rehabilitation	18, 947. 5	18, 438	97. 3	9, 993. 7	9, 017	90. 2	28, 941. 1	27, 455	−5. 1
Blind	197. 7	249	126. 0	0	106	0	197. 7	355	79. 6
Tennessee	28, 175. 3	27, 798	98. 7	13, 780. 7	13, 389	97. 2	41, 956. 0	41, 187	−1. 8
Illinois	53, 714. 6	53, 942	100. 4	12, 104. 5	13, 293	109. 8	65, 819. 1	67, 235	2. 2
Indiana	27, 615. 1	26, 536	96. 4	18, 622. 1	5, 257	28. 2	46, 138. 1	31, 793	−31. 1
Michigan	50, 336. 9	51, 123	101. 6	28, 989. 0	12, 442	42. 9	79, 325. 9	63, 565	−19. 9
Minnesota	13, 510. 7	12, 991	96. 2	5, 027. 5	4, 450	88. 5	18, 538. 2	17, 441	−5. 9
Ohio	52, 313. 7	52, 942	101. 2	8, 007. 6	17, 304	216. 1	60, 321. 4	70, 246	16. 5
Wisconsin	18, 782. 9	18, 675	99. 4	1, 489. 0	7, 077	475. 3	20, 271. 9	25, 752	27. 0
Arkansas	15, 899. 9	16, 785	105. 6	1, 923. 7	9, 193	477. 9	17, 823. 6	25, 978	45. 8
Louisiana	25, 291. 4	26, 037	102. 9	28, 679. 1	16, 824	58. 7	53, 970. 5	42, 861	−20. 6
New Mexico	5, 849. 2	6, 298	107. 7	744. 5	3, 275	439. 9	6, 593. 7	9, 573	45. 2
Oklahoma	14, 170. 0	14, 251	100. 6	2, 172. 2	9, 489	436. 8	16, 342. 1	23, 740	45. 3
Texas	60, 834. 5	61, 422	101. 3	48, 543. 8	27, 457	56. 6	109, 178. 2	88, 879	−18. 6
Iowa	10, 874. 6	11, 145	102. 5	247. 5	3, 494	1, 411. 7	11, 122. 1	14, 639	31. 6
Kansas	8, 485. 3	8, 392	98. 9	5, 710. 7	3, 617	63. 3	14, 196. 0	12, 009	−15. 4
Missouri	25, 044. 5	26, 022	103. 9	4, 779. 0	12, 109	253. 4	29, 823. 5	38, 131	27. 9
Nebraska	5, 765. 9	5, 769	100. 1	806. 9	1, 827	226. 4	6, 572. 8	7, 596	15. 6
Colorado	9, 556. 0	10, 213	106. 9	2, 420. 7	3, 812	157. 5	11, 976. 7	14, 025	17. 1
Montana	3, 871. 4	3, 960	102. 3	433. 5	1, 583	365. 1	4, 305. 0	5, 543	28. 8
North Dakota	2, 306. 0	2, 201	95. 4	309. 9	878	283. 3	2, 615. 9	3, 079	17. 7
South Dakota	2, 553. 8	2, 625	102. 8	123. 8	724	585. 0	2, 677. 6	3, 349	25. 1
Utah	3, 871. 4	3, 880	100. 2	1, 923. 7	2, 401	124. 8	5, 795. 1	6, 281	8. 4
Wyoming	1, 399. 8	1, 492	106. 6	186. 1	490	263. 3	1, 586. 0	1, 982	25. 0
Arizona	10, 133. 0	11, 088	109. 4	1, 923. 7	3, 379	175. 7	12, 056. 7	14, 467	20. 0
California	129, 096. 0	129, 037	100. 0	22, 720. 0	75, 146	330. 7	151, 815. 9	204, 183	34. 5
Hawaii	3, 212. 1	2, 657	82. 7	868. 3	1, 287	148. 2	4, 080. 4	3, 944	−3. 3
Nevada	3, 953. 7	3, 434	85. 9	2, 482. 1	1, 259	50. 7	6, 435. 7	4, 693	−27. 1
Alaska	1, 070. 7	1, 012	94. 5	61. 4	876	1, 427. 2	1, 132. 1	1, 888	66. 8
Idaho	4, 035. 9	4, 079	101. 1	61. 4	1, 354	2, 206. 0	4, 097. 3	5, 433	32. 6
Oregon	14, 416. 8	13, 410	93. 0	3, 290. 0	4, 955	150. 6	17, 706. 8	18, 365	3. 7
Washington	18, 453. 8	19, 259	104. 4	1, 675. 2	9, 865	588. 9	20, 128. 9	29, 124	44. 7

Note.—Supplemental security income rollback cases are included in this tabulation.

TABLE 19.—*BDI State agency disability and SSI case processing data for week ending June 5, 1974* [1]

State	DI weeks work pending	SSI weeks work pending	DI/SSI weeks work pending [2]
New York	10. 2	9. 7	9. 9
Maryland	7. 4	8. 3	7. 9
Illinois	7. 8	10. 8	8. 8
United States	6. 4	6. 7	6. 6

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[1] Rollback cases are included in this report.

[2] Special efforts such as detailing Federal employees from the RO staff have been initiated to assist State agencies with high workloads in case processing. As a result of these efforts, preliminary data for the week ending June 19 shows a reduction in weeks work pending as follows: New York, 7.3; Maryland, 7.3; Illinois, 7.4.

TABLE 20.—*BDI State agency disability and SSI workloads for week ending June 5, 1974* [1]

State	Opening pending	Receipts	Disposed	Closing pending
Disability:				
New York	27, 499	2, [illegible]	4, 036	25, 818
Maryland	3, 816	614	524	3, 906
Illinois	10, 598	1, 059	951	10, 706
United States	211, 198	27, 169	32, 817	205, 550
Supplemental security income:				
New York	35, 115	2, 819	3, 796	34, 138
Maryland	4, 812	1, 028	607	5, 233
Illinois	7, 981	298	624	7, 655
United States	203, 781	19, 898	32, 154	191, 417
Combined DI and SSI totals:				
New York	62, 614	5, 174	7, 832	59, 956
Maryland	8, 628	1, 642	1, 131	9, 139
Illinois	18, 579	1, 357	1, 575	18, 361
United States	414, 979	47, 067	64, 971	396, 967

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[1] Rollback cases are included in this report.

Brief summary of the workload picture across the Nation and three selected State agencies

I. National picture

Substantial and steady reduction has recently occurred in the national case workload. This downward trend is attributable to numerous factors including increased productivity by expanded State agency staffs, utilization of overtime where possible, institution of case processing expedients, and the contribution made by DIRO personnel detailed to assist in the processing of agency backlogs. The improvement nationally can be demonstrated by the figures cited below.

At the close of business June 19, 1974, the total cases pending nationally was 380,865 the lowest total since February 27. DI cases pending dropped below 200,000 for the first time since the beginning of March. The last 8 weeks has seen a drop in DI/SSI weeks work pending from 8 to 6.2, and while the aged caseload (70 days and pending) was at 15.6 percent, the number of such cases has been declining gradually in the last month. Continuing emphasis on clearing aged cases should result in further improvement.

II. Individual States

New York.—Dispositions in the last 5 weeks have exceeded receipts by 10,000, causing the weeks work pending load to decline from 16.7 to 7.3. This is mainly due to the presence of a large Federal strike force in the agency (a team of some 80 Federal and State employees) and improved case productivity of the agency's professional personnel. Emphasis by the strike force currently is being directed at moving a high aged caseload to determinations as soon as possible. State and Federal employees are utilizing extensive amounts of overtime and implementing approved case processing expedients.

Illinois.—The decline in cases on hand in the Illinois agency although not dramatic has nonetheless culminated in reducing the combined weeks work pending from 8.8 to 7.4. For the first time in more than 8 weeks the combined DI/SSI load pending is below 18,000 cases. The improvement in this phase of the workload picture stems from the diligent efforts on the part of the agency's personnel to push the load. The agency has succeeded in alleviating a clerical staff shortage and utilized overtime work for which its clerical employees are reimbursed. We understand also that professional staff members have voluntarily worked overtime without compensation. To assist in moving an increasing aged caseload six detailees from the DIRO regional staff worked in concert with agency specialists. A special task force is reviewing all incoming SSI cases; those on hand nearly 45 days for the purpose of determining whether a presumptive finding of disability would be appropriate.

Maryland.—The agency as of June 26, 1974 had reduced its combined DI/SSI caseload to 8,317 cases which was the equal of 6.6 weeks work pending. This is lower than at any previous point in this quarter. Since average weekly output has been between 1,200 and 1,300 plus, and receipts have begun to level off at under 900 and are expected to continue at this rate, the prospects for continuing improvement appear bright.

Staff question: ***In an emergency situation where a State agency cannot keep up with its social security and SSI disability workload, what is the maximum number of cases that can now be re-routed to BDI for decision without causing untimely decision delay? If a State agency does not wish to accept additional personnel from Baltimore or the regional office, what measures can be taken to assist the State with a backlog of cases or to speed-up the State's processing time?***

With the present on-line computer system, we understand that the checks and denial notices are generated from the State agency. Should it prove necessary to pull SSI cases from the State agency, could a timely check or denial be generated from Baltimore?

Under the present procedures for processing Title II and Title XVI disability cases whereby State agencies fully develop the medical aspects of claims simultaneously with nonmedical development performed by Federal district offices, it would be difficult to transfer cases to Baltimore prior to the SA's having fully developed the medical evidence. This development requires local knowledge of medical resources and established local medical relationships. It could be handled from Baltimore only with great difficulty and would be an inefficient way to operate. The SA's could, however, transfer cases to Baltimore for a decision, after the evidence is gathered. This too, would not be very effective since cases should not be transferred until there is sufficient evidence for a decision, which would require a professional review of the claim. If the State agency reviewed the case to this extent, it would be tantamount to making the decision, and little additional time would be necessary to complete the determination.

For these reasons, we are encouraging State agencies to hire additional staff and train them as quickly as possible to deal with current and expected workloads. Wherever feasible, overtime work is being used in the State agencies and outside contracting for clerical help (e.g., Kelly Girls) is being utilized to deal with clerical backlogs. Regional office technical staff are also being assigned temporarily to State agencies to help process workloads and States are generally accepting these details where the need exists. A limited number of details from Baltimore could also be made available if all other means were exhausted. Full emphasis is being given to building up State agency capability—rather than moving cases into Baltimore.

With respect to the second part of this question, a limited volume of SSI disability decisions could be entered into the computer system for generating denial notices and benefit checks in Baltimore if necessary.

2. PROCESSING TIME

Table 21 shows median and mean processing time for initial disability determination by station and for this fiscal year to specified date and for February, 1974. Table 22 shows median time in days for State Agency initial determinations cleared in June, 1967 through 1973. Table 23 shows the number and percent of State Agencies by average processing time for specified month for the years 1967–1973.

TABLE 21.—*Average processing time of completed initial disability cases*

Station	Fiscal year 1974 to February 1974		February 1974	
	Median	Mean	Median	Mean
Allowances:				
Total Time	79	89	78	97
District Office Time Date of Application to:				
I. D/O 1st Trans	1	4	1	4
II. D/O Final Time	15	20	16	22
State Agency Time	33	41	35	43
Bureau of Disability Insurance Time	30	35	20	36
Denials:				
Total Time	61	70	52	58
District Office Time Date of Application to:				
I. D/O 1st Trans	2	5	2	5
II. D/O Final Trans	16	20	17	21
State Agency Time	36	46	30	42

NOTE.—There is no processing time on denials for the Bureau of Disability Insurance as review on these cases is done after a notice of denial is sent to the claimant. This post-adjudication was initiated in January 1974.

TABLE 22.—*Average elapsed processing time for State agency initial determinations, in median days, for claims cleared during June in each year*

State agency	1967 [1]		1968		1969		1970		1971		1972 all [2]	1973 all [2]
	Not developed	Developed	Not developed	Developed	Not developed	Developed	Not developed	Developed	Not developed	Developed		
United States	2	39	3	41	2	34	3	36	5	44	35	35
Alabama	1	33	2	35	1	25	0	30	12	32	31	24
Alaska	3	70	5	28	4	35	8	41	12	42	52	62
Arizona	3	40	4	40	2	33	7	43	39	58	43	42
Arkansas	1	21	1	27	1	20	10	22	9	31	22	20
California	4	43	4	46	1	27	2	32	2	33	37	38
Colorado	12	78	6	56	5	56	6	59	4	42	48	43
Connecticut	4	61	4	82	7	63	3	42	43	74	38	43
Delaware	1	27	4	22	2	29	2	24	30	44	42	28
District of Columbia	4	50	3	45	2	58	4	76	5	83	59	36
Florida	1	30	1	35	1	30	1	21	1	25	27	24
Georgia	1	41	1	38	1	22	0	25	1	31	32	35
Hawaii	1	30	1	32	1	27	2	32	27	59	40	40
Idaho	1	36	3	33	1	24	2	35	2	37	41	41
Illinois	2	36	5	49	3	38	3	34	34	66	33	35
Indiana	4	45	13	51	7	51	5	43	12	66	42	40
Iowa	3	43	4	36	1	33	2	34	3	34	31	34
Kansas	1	41	3	36	1	28	3	33	4	46	45	37
Kentucky	1	36	2	36	1	32	5	40	2	40	49	20
Louisiana	3	27	3	30	1	27	1	32	1	31	32	30
Maine	3	48	5	41	1	41	0	36	20	48	23	24
Maryland	3	48	3	44	2	37	4	40	4	47	48	40
Massachusetts	1	40	1	40	2	50	1	48	3	48	21	38
Michigan	3	57	3	50	5	48	5	49	4	57	40	39

Minnesota	5	57	4	43	7	47	6	49	38	62	36	38
Mississippi	1	34	1	39	1	28	0	29	2	28	26	22
Missouri	1	33	1	26	1	24	1	24	22	39	29	30
Montana	1	31	1	27	1	26	1	30	21	49	30	24
Nebraska	1	22	3	30	1	32	7	29	6	50	40	34
Nevada	1	32	4	40	5	13	3	30	33	88	28	42
New Hampshire	6	35	9	43	8	58	7	38	5	42	36	39
New Jersey	5	41	3	33	2	23	4	25	27	48	30	33
New Mexico	1	28	1	33	1	20	2	35	25	56	32	34
New York	2	33	6	45	5	27	6	29	5	26	36	45
North Carolina	1	38	1	42	1	32	3	48	13	38	39	34
North Dakota	4	35	3	49	2	47	1	30	12	33	24	31
Ohio	1	40	4	43	4	40	7	48	50	86	41	33
Oklahoma	1	45	3	35	1	26	2	22	11	43	29	26
Oregon	3	39	4	48	1	26	3	34	25	45	35	41
Pennsylvania	2	46	2	50	1	45	2	57	5	69	53	41
Rhode Island	1	42	3	44	1	39	4	34	28	76	46	42
South Carolina	1	33	1	38	1	22	2	29	8	35	34	37
South Dakota	37	73	4	32	1	22	0	16	6	32	25	29
Tennessee	1	29	1	38	1	34	0	29	1	28	27	35
Texas	1	30	2	33	1	27	2	32	2	31	31	35
Utah	4	44	3	37	1	34	2	29	13	68	36	35
Vermont	1	26	1	18	1	10	0	13	1	20	15	16
Virginia	3	54	2	39	3	41	3	40	4	48	33	30
Washington	3	40	3	38	3	29	3	33	3	39	38	44
West Virginia	6	50	6	55	3	47	4	48	4	52	41	41
Wisconsin	1	38	4	32	5	53	2	32	28	71	34	29
Wyoming	1	21	3	29	2	34	3	20	2	23	21	19
Guam	0	0	0	0	0	0	0	0	0	2	16	0
Puerto Rico	2	55	3	54	5	66	6	62	5	63	58	56

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[1] Data for August.

[2] Data for breakdown by developed and nondeveloped cases not kept.

TABLE 23.—*Number and percent of State jurisdictions by average processing time, cases requiring development, and cases not requiring development*

Average processing time (in days)	Jurisdictions	
	Number	Percent
CASES REQUIRING DEVELOPMENT—AUGUST 1967 [1]		
All jursidictions	53	100.0
Under 20	0	0
20 to 29	8	15.1
30 to 39	18	33.9
40 to 49	17	32.1
50 to 59	6	11.3
60 to 69	1	1.9
70 and over	3	5.7
CASES NOT REQUIRING DEVELOPMENT—AUGUST 1967 [1]		
All jurisdictions	53	100.0
Under 5	46	86.8
5 to 9	5	9.4
10 to 14	1	1.9
15 and over	1	1.9
CASES REQUIRING DEVELOPMENT—JUNE 1968 [1]		
All jursidictions	53	100.0
Under 20	1	1.9
20 to 29	6	11.3
30 to 39	22	41.5
40 to 49	16	30.2
50 to 59	7	13.2
60 to 69	0	0
70 to 79	0	0
80 and over	1	1.9
CASES NOT REQUIRING DEVELOPMENT—JUNE 1968 [1]		
All jurisdictions	53	100.0
Under 5	44	83.0
5 to 9	8	15.1
10 and over	1	1.9
CASES REQUIRING DEVELOPMENT—JUNE 1969 [1]		
All jurisdictions	53	100.0
Under 20	2	3.8
20 to 29	21	39.6
30 to 39	13	24.5
40 to 49	9	17.0
50 to 59	6	11.3
60 and over	2	3.8

See footnotes at end of table.

TABLE 23.—*Number and percent of State jurisdictions by average processing time, cases requiring development, and cases not requiring development*—Continued

Average processing time (in days)	Jurisdictions	
	Number	Percent
CASES NOT REQUIRING DEVELOPMENT—JUNE 1969 [1]		
All jurisdictions	53	100.0
Under 5	42	79.2
5 to 9	10	18.9
10 and over	1	1.9
CASES REQUIRING DEVELOPMENT—JUNE 1970 [1]		
All jurisdictions	52	100.0
Under 20	2	3.8
20 to 29	14	27.0
30 to 39	19	36.6
40 to 49	13	25.0
50 to 59	2	3.8
60 to 69	1	1.9
70 and over	1	1.9
CASES NOT REQUIRING DEVELOPMENT—JUNE 1970 [1]		
All jurisdictions	[2] 45	100.0
Under 5	32	71.1
5 to 9	12	26.7
10 and over	1	2.2
CASES REQUIRING DEVELOPMENT—JUNE 1971 [1]		
All jurisdictions	53	100.0
Under 20	1	1.9
20 to 29	6	11.3
30 to 39	14	26.4
40 to 49	14	26.4
50 to 59	6	11.3
60 to 69	6	11.3
70 to 79	3	5.7
80 and over	3	5.7
CASES NOT REQUIRING DEVELOPMENT—JUNE 1971 [1]		
All jurisdictions	[3] 52	100.0
Under 10	29	55.8
10 to 19	7	13.5
20 to 29	9	17.3
30 to 39	5	9.6
40 to 49	1	1.9
50 and over	1	1.9

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[1] Data reported by State agencies, based on initial determinations disposed of by the States during the months indicated. (Data for June 1967 is not available). Average processing time expressed in median days.

[2] Excludes 7 jurisdictions where there were no cases not requiring development during June 1970.

[3] Excludes 1 jurisdiction where all cases required development during June 1971.

TABLE 24.—*Number and percent of State jurisdictions by average processing time, all cases*

Average processing time (in days)	Jurisdictions	
	Number	Percent
ALL CASES—JUNE 1972 [1]		
All jurisdictions	53	100. 0
Under 20	2	3. 8
20 to to 29	12	22. 6
30 to 39	21	39. 6
40 to 49	14	26. 4
50 to 59	4	7. 6
60 and over	0	0
ALL CASES—JUNE 1973 [1]		
All jurisdictions	52	100. 0
Under 20	2	3. 8
20 to 29	11	21. 2
30 to 39	23	44. 3
40 to 49	14	26. 9
50 to 59	1	1. 9
60 and over	1	1. 9

[1] Data reported by State agencies, based on initial determinations disposed of by the States during the months indicated. Includes both cases requiring development and cases not requiring development. Average processing time expressed in median days.

Staff question: ***In fiscal 1973, how many States were able to meet the processing time goals stated in the Disability Insurance State Manual of—***

7 days from receipt in the State agency for case that requires no additional development;

35 days from the receipt for development cases which do not include a consultative examination; and

60 days from receipt for development cases which do require a consultative examination.

Please list States which met goals under each category and list the ten States which were the slowest in each category.

Since FY 1971, with the advent of Simultaneous Development (a procedure where the non-disability issues of a claim are developed by the district offices simultaneously with the development of the disability issues in the claim by the State agency) we have not maintained the statistical data by the three requested categories. Now, all cases are lumped together in maintaining processing time data. No par has been set.

The processing time figures calculated now by State are the percentage of cases cleared and the cumulative percentage on succeeding days. From this, a monthly report is prepared and issued which shows the median days processing time and the percentage cleared in selected time periods for each State. The report for June 1973, the last month in fiscal year 1973, is attached as an example. Thus, in responding to the request, we are listing below those State agencies which were under the national median time of 35 days and the ten States which had the largest median processing time for June.

TABLE 25.—*Processing time-median days; June 1973; national median, 35 days*

	Days
SA's bettering the national median:	
Vermont	16
Wyoming	19
Kentucky	20
Arkansas	20
Mississippi	22
Maine	24
Alabama	24
Florida	24
Montana	24
Oklahoma	26
Delaware	28
South Dakota	29
Wisconsin	29
Virginia	30
Missouri	30
North Dakota	31
New Jersey	33
Ohio	33
SA's bettering the national median—Continued	
North Carolina	34
Iowa	34
Nebraska	34
Slowest 10 States:	
Alaska	62
Puerto Rico	56
New York	45
Washington	44
Connecticut	43
Colorado	43
Rhode Island	42
Arizona	42
Nevada	42
Pennsylvania	41
West Virginia	41
Alaska	41
Oregon	41

Table 26.—*State agency initial determination processing time expressed as a percentage of total claims received in BDI for the month of June 1973*

Completed in:	Median days	45 days	70 days	90 days	105 days	120 days
United States	35	60.8	81.5	91.3	95.2	97.4
Boston:						
Connecticut	43	50.9	76.5	88.8	93.5	95.4
Maine	24	83.3	95.1	98.5	99.4	99.4
Massachusetts	38	57.2	76.1	86.6	92.1	95.6
New Hampshire	39	61.7	79.4	88.9	93.9	96.7
Rhode Island	42	51.8	70.3	81.5	89.6	94.6
Vermont [1]	16	96.1	---	---	---	---
New York:						
New Jersey	33	63.8	86.4	94.9	97.0	98.1
New York	45	49.8	74.4	87.4	93.2	96.7
Puerto Rico	56	30.2	72.1	88.6	94.7	97.7
Philadelphia:						
Delaware [2]	28	72.7	89.8	97.7	---	---
District of Columbia	36	55.6	74.6	88.7	93.1	95.6
Maryland	40	54.7	77.8	90.3	94.1	97.2
Pennsylvania	41	53.3	73.7	86.4	92.2	95.1
Virginia	30	66.1	80.5	90.6	95.2	97.3
West Virginia	41	54.5	76.4	89.1	94.7	97.1
Atlanta:						
Alabama	24	78.0	90.0	95.7	97.6	98.5
Florida	24	79.0	92.7	97.5	98.7	99.4
Georgia	35	59.8	80.1	90.3	94.7	96.8
Kentucky	20	68.5	84.9	92.9	96.0	97.9
Mississippi	22	79.9	92.9	97.2	98.6	99.2
North Carolina	34	62.0	81.0	88.7	92.7	95.7
South Carolina	37	59.1	85.0	94.5	97.7	99.0
Tennessee	35	61.6	80.7	92.5	97.1	98.5
Chicago:						
Illinois	35	67.0	82.1	91.6	95.2	57.8
Indiana	40	57.3	80.6	91.6	95.2	97.3
Michigan	39	57.9	61.9	92.0	95.9	98.0
Minnesota	38	59.4	80.3	91.3	95.4	98.0
Ohio	33	64.7	84.3	92.7	96.1	98.0
Wisconsin	29	73.2	90.8	96.7	98.7	99.7
Dallas:						
Arkansas	20	88.0	96.6	98.9	99.7	99.8
Louisiana	30	66.0	85.9	94.0	97.3	98.6
New Mexico	34	64.9	84.5	91.4	95.4	96.8
Oklahoma	26	76.2	92.8	96.9	98.6	99.1
Texas	35	61.9	84.2	93.6	97.0	98.5
Kansas City:						
Iowa	34	62.4	80.6	93.1	96.8	98.5
Kansas	37	57.1	79.9	90.3	95.4	97.6
Missouri	30	66.6	85.7	94.1	97.0	99.0
Nebraska	34	66.1	86.9	93.6	95.0	98.0
Denver:						
Colorado	43	51.1	71.5	83.9	88.3	93.9
Montana	24	83.3	95.6	98.5	99.0	
North Dakota [3]	31	68.0	87.7	91.0	94.3	95.9
South Dakota	29	69.8	91.4	97.4	98.3	98.3
Utah	35	62.1	85.3	93.7	98.4	99.5
Wyoming [4]	19	87.7	94.5			
San Francisco:						
Arizona	42	52.7	75.1	87.8	93.5	97.9
California	38	57.9	79.8	89.4	93.8	96.6
Guam	---	---	---	---	---	---
Hawaii	40	57.5	78.2	93.7	95.4	97.1
Nevada	42	54.0	78.2	91.1	96.0	97.6
Seattle:						
Alaska	62	39.5	65.8	81.6	97.4	---
Idaho	41	52.4	76.0	87.8	94.8	98.3
Oregon	41	53.5	71.3	84.1	89.8	94.2
Washington	44	50.1	72.0	84.9	89.4	93.4

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[1] 100 percent in 50 days.

[2] 100 percent in 179 days.

[3] 100 percent in 117 days.

[4] 100 percent in 86 days.

TABLE 27.—*Ranked in State order by percentage of cases completed in 45, 70, and 90 days*

Name of State	45 days	Name of State	70 days	Name of State	90 days
United States	60.8	United States	81.5	United States	91.3
Vermont	96.1	Vermont	100.0	Vermont	100.0
Arkansas	88.0	Arkansas	96.6	Wyoming	100.0
Wyoming	87.7	Montana	95.6	Arkansas	98.9
Maine	83.3	Maine	95.1	Maine	98.5
Montana	83.3	Wyoming	94.5	Montana	98.5
Mississippi	79.9	Mississippi	92.9	Delaware	97.7
Florida	79.0	Oklahoma	92.8	Florida	97.5
Alabama	78.0	Florida	92.7	South Dakota	97.4
Oklahoma	76.2	South Dakota	91.4	Mississippi	97.2
Wisconsin	73.2	Wisconsin	90.8	Oklahoma	96.9
Delaware	72.7	Alabama	90.0	Wisconsin	96.7
South Dakota	69.8	Delaware	89.8	Alabama	95.7
Kentucky	68.5	North Dakota	87.7	New Jersey	94.9
North Dakota	68.0	Nebraska	86.9	South Carolina	94.5
Illinois	67.0	New Jersey	86.4	Missouri	94.1
Missouri	66.6	Louisiana	85.9	Louisiana	94.0
Virginia	66.1	Missouri	85.7	Hawaii	93.7
Nebraska	66.1	Utah	85.3	Utah	93.7
Louisiana	66.0	South Carolina	85.0	Nebraska	93.6
New Mexico	64.9	Kentucky	84.9	Texas	93.6
Ohio	64.7	New Mexico	84.5	Iowa	93.1
New Jersey	63.8	Ohio	84.3	Kentucky	92.9
Iowa	62.4	Texas	84.2	Ohio	92.7
Utah	62.1	Illinois	82.1	Tennessee	92.5
North Carolina	62.0	Michigan	81.9	Michigan	92.0
Texas	61.9	North Carolina	81.0	Illinois	91.6
New Hampshire	61.7	Tennessee	80.7	Indiana	91.6
Tennessee	61.6	Indiana	80.6	New Mexico	91.4
Georgia	59.8	Iowa	80.6	Minnesota	91.3
Minnesota	59.4	Virginia	80.5	Nevada	91.1
South Carolina	59.1	Minnesota	80.3	North Dakota	91.0
California	57.9	Georgia	80.1	Virginia	90.6
Michigan	57.9	Kansas	79.9	Georgia	90.3
Hawaii	57.5	California	79.8	Kansas	90.3
Indiana	57.3	New Hampshire	79.4	Maryland	90.3
Massachusetts	57.2	Hawaii	78.2	California	89.4
Kansas	57.1	Nevada	78.2	West Virginia	89.1
District of Columbia	55.6	Maryland	77.8	New Hampshire	88.9
Maryland	54.7	Connecticut	76.5	Connecticut	88.8
West Virginia	54.5	West Virginia	76.4	District of Columbia	88.7
Nevada	54.0	Massachusetts	76.1	North Carolina	88.7
Oregon	53.5	Idaho	76.0	Puerto Rico	88.6
Pennsylvania	53.3	Arizona	75.1	Arizona	87.8
Arizona	52.7	District of Columbia	74.6	Idaho	87.8
Idaho	52.4	New York	74.4	New York	87.4
Rhode Island	51.8	Pennsylvania	73.7	Massachusetts	86.6
Colorado	51.1	Puerto Rico	72.1	Pennsylvania	86.4
Connecticut	50.9	Washington	72.0	Washington	84.9
Washington	50.1	Colorado	71.5	Oregon	84.1
New York	49.8	Oregon	71.3	Colorado	83.9
Alaska	39.5	Rhode Island	70.3	Alaska	81.6
Puerto Rico	30.2	Alaska	65.8	Rhode Island	81.5

[From the Disability Insurance State Manual, pt. IV, Fiscal and Administrative Management]

470. MANAGEMENT REQUIREMENTS, GUIDES, AND OPERATING GOALS

471. General.—In the light of the concern to expedite case processing at all stations, consistent with quality adjudication, there has been developed from accumulated operating data and related information about State agency operations, certain operating goals, guides, and procedures for a number of areas of the determination process, and a collection of operating guides that represent practices in general use.

The data derived from management activities, either as required by the Bureau or as a result of a State agency's appraisal of its own operations, are essential for use in the BOASI regional and central office in appraising the current status of disability operations in the States, in particular relation to the time required to process disability cases. This is a matter of interest and concern at the national and State level. The data derived from these and similar activities are even more essential for internal use by the agency in the continuing evaluation of the total disability operation in the State. This need is especially pertinent in those States that have not had the opportunity to develop techniques or controls to point up the processes or stages in the disability operation which are in need of refinement.

472. Operating goals

472.1 General.—It is necessary to continue to give emphasis to reducing the total time involved in processing applications for disability. This goal is a major concern in the Bureau. In OASI district offices and DDO a number of significant changes in procedures have resulted in more prompt processing of disability applications. The case processing goals provided in section 472.2 were developed on the basis of State agency experience. To accomplish such goals State agencies will need to see that operating procedures permit assignment and processing of cases currently as received.

472.2 Case processing goals.—State agency experience has demonstrated that reasonable operating goals are:

(1) *No Development Cases.*—Process, within 7 days of receipt in the State agency, a case that requires no additional development.

(2) *Development Cases.*—Process within (1) 35 days cases which do not include a consultative examination as part of State agency development; and (2) 60 days cases which require a consultative examination as part of the development.

C. FEDERAL SUPERVISION

1. MODEL AGREEMENT

The legal and administrative framework for the agreements with State agencies is found in sections 221 and 222 of the Social Security Act. The agreement was developed by the Department of HEW with the advice and assistance of the States Council Committee on Social Security Relationships. It has served as the basis for negotiations with the contracting State agencies and is basically the same for each of the 54 contracting units.

Revised model agreement (to carry out provisions of the Social Security Act, as amended) May 31, 1973

The Secretary of Health, Education, and Welfare, hereinafter referred to as the Secretary, and (*Name of State agency*), hereinafter referred to as "the State agency," acting on behalf of the State of (*Name of State*), for the purpose of carrying out the provisions of the Social Security Act, as amended, hereinafter referred to as "the Act", relative to the making of determinations of disability by State agencies on behalf of the Secretary, hereby agree to the following.

A. Definitions

For purposes of this agreement—

1. the term "disability" means "disability" or "blindness" as defined in Section 216(i) and 223 of Title II or Section 1614 (a) (2) and (3) of Title XVI of the Social Security Act, as amended;

2. the term "determination of disability" includes one or more of the following determinations: a. whether or not an individual is under a disability; b. the date as of which the individual's disability began; and c. the date as of which the individual's disability ceased;

3. the term "Managing Trustee" means the Federal official designated in the Social Security Act, and directed by such Bureau of Disability Insurance Act, to pay from the Trust Funds (established by Section 201 thereof) such monies as may be certified by the Secretary to him for payment;

4. the term "Secretary" means the Secretary of Health, Education, and Welfare or his delegate; and

5. the term "necessary cost" shall include indirect as well as direct costs.

B. Administration

1. Subject to the provisions of paragraph 2. of this part, the State agency, upon request by the Secretary, will make determinations of disability with respect to individuals in the State in the following classes of cases arising under Title II of the Act:

a. Cases arising under the several sections of Title II calling for determination of disability.

b. Any case specifically excluded from the class of cases referred to in a. above in which the individual has submitted evidence indicating probability of the existence of a disability or of the continuation of a previously determined disability, but the Secretary finds from all the circumstances of the case that medical or other consultation is warranted in order to make a proper initial or current determination of disability and that such consultation can be accomplished more expeditiously and effectively by the State agency.

2. There shall be excluded from the classes of cases referred to in paragraph 1.*a.*:

a. Any case in which the individual has completed 10 years of service in the railroad industry as that term is defined in section 1(f) of the Railroad Retirement Act of 1937, as amended, or has been awarded an annuity under such act;

b. Any case in which an individual, determined to be under a disability as defined in Section 216(i) of the Act, files an application for disability insurance benefits under the Act, but only insofar as the case requires a determination that such disability has (or has not) continued up to and including the effective date of his application for disability insurance benefits;

c. Any case in which it is clear and uncontradicted that the date of onset of the applicant's alleged disability is more than one year after (i) the last day of the period prescribed in Section 202(d)(6) or 202(e)(5) or 202(f)(6) of the Act, as appropriate, or (ii) the date he last met the requirements of Section 216(i)(3) or Section 223(c)(1) of the Act, as appropriate, or the alleged onset of his disability is due to traumatic injury which occurred after the date he last met the requirements of such section;

d. Any case in which an applicant who was determined not to be under a disability and (i) as to whom the period described in Section 202(d)(6) or 202(e)(5) or 202(f)(6) of the Act, as appropriate, had expired on or prior to the date of such determination, or (ii) who at no time after the date of such determination met the requirements of Section 216(i)(3) of the Act or Section 223(c)(1) of the Act, as appropriate, files a new application;

e. Any case based on an application by an applicant who had previously filed a valid request for a hearing before an administrative law judge of the Social Security Administration, but the final decision of the Secretary on the disability application on which hearing was requested was not made when the subsequent application was filed;

f. Any case that falls within the jurisdiction of the Bureau of Hearings and Appeals;

g. Any case in a. of Paragraph 1. of this Part, with respect to which it is mutually agreed by the State agency and the Secretary that after consideration of the total number of pending and prospective applications in the State, the determination with respect to disability in such case can be made more expeditiously by the Secretary;

h. Any case in which the issue to be resolved in the determination of disability is solely whether or not the individual is or was engaging in substantial gainful activity as described in Section 223(d)(4);

i. Any case to which a prior Title XVI determination is applicable.

3. In making determinations of disability, the State agency will apply the term "disability" (as defined in Part A of this agreement) in conformity with Sections 216(i) and 223 of Title II or Section 1614(a)(2) and (3) of Title XVI of the Act, the regulations issued pursuant thereto, and such standards as may be promulgated by the Secretary.

4. The Secretary shall, if he finds necessary, promulgate standards, with respect to determinations of disability, to insure:

a. the prompt and orderly processing of requests for such determinations;

b. equality in the treatment of individuals within the State; and

c. equality in the treatment of such individuals with the treatment accorded individuals in other States with which similar agreements have been entered into by the Secretary.

If such standards are promulgated, the State agency will adopt such policies and procedures as may be necessary to conform to such standards so that the provisions of *a.*, *b.* and, insofar as practicable, the provisions of *c.*, are effectuated.

5. In any case in which the State agency is requested to make a determination of disability, the Secretary will furnish to the State agency any pertinent evidence he may have relative to the individual. The State agency will, in accordance with such standards as may be promulgated by the Secretary, secure from or through the individual or from other sources such additional medical or other evidence as the State agency considers necessary to enable it to make a determination of disability.

6. Each determination of disability will be certified by the State agency to the Secretary on such form or forms as may be provided by the Secretary. The State agency will also furnish the Secretary with the evidence considered in making its determination of disability in individual cases. Any such evidence forwarded to the Secretary by the State agency will be returned upon request. Except as provided in subsections (c) and (d) of Section 221 of the Social Security Act, any determination of disability made by the State agency shall be the determination of the Secretary for the purposes of Title II of the Act. (For purposes of Title XVI of the Act see B.8.) The State agency shall not, however, be a party to or assume any responsibility for defending any determination made by the Secretary pursuant to Title II and Title XVI of the Act. For Title II determinations notification to the individual of the determination of disability will be made by the Secretary at the same time such individual is notified whether his insurance rights under Title II of the Act are preserved on account of his disability or whether he is entitled to a benefit under Title II of the Act.

7. From time to time the Secretary will review such standards as he may issue pursuant to this agreement and, to the extent feasible, will consult with, and take into consideration the experience of, States or such group of States as he may consider representative, with which agreements have been entered into to carry out the disability provisions of the Act, to determine the standards that are necessary and sufficient to effectuate the purposes of this agreement.

8. Subject to the provisions of paragraph a. of this Part, the State agency, upon request by the Secretary, will make determinations of disability or blindness, or render such other assistance as may be mutually agreed upon, with respect to individuals in the State in cases arising under the several sections of Title XVI. All State agency determinations will be determinations of the Secretary unless the Secretary reviews and revises the State agency determination. With respect to such review and revisions of determinations, the Secretary will maintain appropriate liaison and consultation with State agencies.

a. There may be excluded from the cases arising under the several sections of Title XVI:

(1) Any case to which a prior Title II determination is applicable.

(2) Any case in which the issue to be resolved in the determination of disability is solely whether or not the individual is or was engaging in substantial gainful activity.

(3) Any case of obvious and clear-cut disability where there is no reasonable possibility that a contrary result could be reached.

(4) Any case that falls within the jurisdiction of the Bureau of Hearings and Appeals.

(5) In the absence of a specific request by the Secretary, any class of case requiring a redetermination involving a previous finding of disability or blindness as defined in an appropriate State plan in effect for the month of October 1972 under either Title X or XIV, or XVI and for which aid or assistance was granted for December 1973.

(6) Any other case or class of cases where it is mutually agreed by the State agency and the Secretary that the determination with respect to disability can be made more expeditiously by the Secretary.

b. There shall be removed from exclusion in *a.* above any case where it is mutually agreed by the State agency and the Secretary that the determination with respect to disability in such case can be made more expeditiously by the State agency.

c. At the request of the Secretary, the State agency will decide whether an individual is presumptively disabled for payment of benefits under Section 1631(a)(4)(B).

C. Personnel

In carrying out this agreement, the State agency further agrees that it will comply in all respects with the provision set out in Section 202 of Executive Order 12246 of September 24, 1965, as amended by Executive Order 11375 of October 13, 1967. The State agency will also, except as may be inconsistent with the foregoing, adhere to its approved personnel standards in its plan under the Vocational Rehabilitation Act (29 U.S.C. 31 et. seq.), or if there are no approved personnel standards for a particular position, such standard in the selection, tenure of office, or compensation of any individual in such position as are consistent with the personnel standards in its plan under the Vocational Rehabilitation Act.[1]

D. Organization

1. As may be agreed upon by the State agency and the Secretary, the State agency will provide such facilities, employ such qualified personnel, and provide such medical consultative services as are necessary to develop expeditiously

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[1] This sentence is to be used if the State agency administers a plan approved under the Vocational Rehabilitation Act. If the State agency is some other agency and follows a merit system, use the following sentences instead: "The State agency will also, except as may be inconsistent with the foregoing, apply such standards as are consistent with the provisions of the merit system under which it operates. If there is no approved personnel standard for such position, the State agency will, in the selection, tenure of office or compensation of any individual in such position apply such standards as are consistent with the merit system under which it operates."

If the State agency is some other agency and does not follow a merit system, use the following sentence: "The State agency will also except as may be inconsistent with the foregoing, follow 'Standards for a Merit System of Personnel Administration' issued by the Department of Health, Education, and Welfare, Social Security Administration, September 1, 1948, 12 amended."

evidence with respect to disability determinations. Such personnel shall be subject to the jurisdiction of the State agency. To the extent that Federal funds are authorized by the Secretary under G.2, the State agency shall apply no restrictions such as a freeze on personnel hiring, a prohibition against overtime work, or other curtailment of facilities needed to carry out the provisions of this agreement in a satisfactory manner, unless such restrictions are required by State law.[2]

2. The determination of disability based upon the evidence developed by such personnel shall be made by a medical consultant and by another individual or individuals qualified to interpret and evaluate medical reports relating to the physical or mental impairment (as referred to under the definition of "disability" in Part A of this agreement) and to determine the capacity of the individual, with respect to whom a determination of disability is necessary, to engage in substantial gainful activity. The personnel utilized by the State agency to make determinations of disability shall be placed in such offices as may be agreed upon by the State agency and the Secretary.

3. The State agency will establish cooperative working relationships with other public agencies concerned with the problems of the disabled and, insofar as practicable, utilize the services, facilities and records of such agencies:

a. to assist the State agency in the development of evidence with respect to and in the making of determinations of disability; and

b. to assure that the Congressional policy promulgated in the Act, relative to the referral of disabled individuals for rehabilitation services, will be carried out effectively. Such public agencies may be reimbursed for such services, facilities or records furnished pursuant to a. and the State agency shall include such costs in the estimates of anticipated costs and reports of actual expenditures furnished pursuant to Part G.[3]

4. Upon request of the Secretary, personnel employed or utilized by the State agency in carrying out the provisions of this agreement will be made available to attend such meetings or conferences either within or outside the State as may be sponsored by the Secretary for furthering the purposes of this agreement except as prohibited by State law.

E. *Medical and other examinations* [4]

1. In making arrangements for medical or other examinations or services necessary to make determinations of disability, the State agency will use the same rates of payment as it uses to purchase the same service in the State program it administers. In making such arrangements, the State agency will not bind itself to pay any fee in excess of the amount that would be paid by the regular State program to the same medical source for the same service.

2. Where a service is not used in the regular program, the State agency will not bind itself to pay any fee or cost for such service which is in excess of the highest rate paid by Federal or State agencies in the State for the same or a similar type of service.

F. *Reports and records*

The State agency will make such reports in such form and containing such information as the Secretary may require, and will comply with such provisions as the Secretary finds necessary to insure the correctness of such reports, including provisions made for the inspection and review of fiscal, statistical and other records and the review of operations within the scope of this agreement.

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[2] The last sentence is an optional provision.

[3] This sentence is to be used if the State is one to which funds are made available to the State in advance of expenditures. If the State is one which is reimbursed for actual expenditures, the words "estimates of anticipated costs and" should be omitted.

[4] The following provisions are to be used in those situations where the State agency is an independent organization:

1. In making arrangements for medical or other examinations or services, the State agency will use the same rates of payment as established by the agency of the State administering a plan under the Vocational Rehabilitation Act. In making such arrangements, the State agency will not bind itself to pay any fee in excess of the amount that would be paid by the agency of the State administering a plan under the Vocational Rehabilitation Act to the same medical source for the same service.

2. Where a service is not used in the Vocational Rehabilitation program, the State agency will not bind itself to pay any fee or cost for such service which is in excess of the highest rate paid by Federal or State agencies in the State for the same or a similar type of service.

G. Fiscal

1. The Secretary will provide funds in advance, as may be mutually agreed upon, for the necessary cost to the State agency of making determinations of disability authorized by this agreement. Such funds will either be paid periodically by the Managing Trustee to ---------- [5] upon certification by the Secretary, or, at the option of the Secretary, will be made available for draft by one of the officials designated by the State for this purpose against letter of credit drawn on a Federal Reserve Bank.[6] Such funds will be used solely for such expenses. Where, for purposes of the State program it administers, the State agency utilizes any service or material purchased or contracted for by it pursuant to this agreement, the cost of such services or material shall, pursuant to standards issued by the Secretary, be prorated and only that part which is attributable to the making of disability determinations authorized by this agreement shall be considered a necessary cost for the purpose of this agreement.

2. The State agency will submit estimates of anticipated costs for such periods, at such times, and in such manner as may be requested by the Secretary. After considering all pertinent information, the Secretary will determine the amount of funds that are necessary for the State agency to administer this agreement for a particular period and that are available to keep within the limits of Federal funds allocated to carry out the purposes of the Act. The Secretary will notify the State agency the amount which will be certified for payment to it, or made available to it, for such period. The State agency will not incur or make expenditures for such period which will exceed the amount the Secretary certifies or makes available for such period unless in advance of making or incurring such expenditures the State agency obtains approval of the Secretary for such expenditures.

3. After the close of a period for which funds have been certified in advance to the State agency, the State agency will submit a certified report of its actual expenditures for such period in such manner and within such time as may be designated by the Secretary. After considering all the pertinent information, the Secretary will determine whether such expenditures were necessary in making determinations of disability authorized by this agreement under standards in effect at the time such expenditures were made or incurred. If, pursuant to such standards, the Secretary determines that any such expenditure was not necessary for such purpose, the Secretary shall so inform the State agency of tentative exceptions taken, with full explanation of such tentative exceptions. The State agency will be given a reasonable length of time to justify such expenditures. If such expenditures cannot be justified by the State agency, the total amount of expenditures actually made and incurred in such period shall be reduced by any expenditures determined by the Secretary to be not necessary in making determinations of disability authorized by this agreement. The difference between the advance payment made to the State agency and the expenditures determined to be necessary for such period will be adjusted, within the limits of available funds, by either appropriate increase or appropriate reduction in the amount certified for advance by the Secretary for a subsequent period.

(Or [7]—)

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[5] There should be inserted here the appropriate State official who is authorized to act as custodian of the monies paid by the Federal government to the State to carry out this agreement. Indicate title of office, not name of incumbent.

[6] If the State agency is one which does not receive funds in advance but is reimbursed for actual expenditures, substitute the following two sentences for the first two sentences of this paragraph:

"The Secretary will provide funds by way of reimbursement, as may be mutually agreed upon, for the necessary cost to the State agency of making determinations of disability authorized by this agreement. Such funds will be paid periodically by the Managing Trustee to ---------- upon certification by the Secretary."

[7] Optional clauses 3 are set out, the first to be used if the State is one to which funds are advanced, the second if the State is one which is reimbursed for expenditures by it.

3. Where funds are to be paid to the State agency by way of reimbursement for expenditures made or incurred by the State agency in a particular period, the State agency will submit a certified report of such expenditures in such manner and within such time as may be designated by the Secretary. After considering all the pertinent information, the Secretary will determine whether such expenditures were necessary in making determinations of disability authorized by this agreement under standards in effect at the time such expenditures were made or incurred. If, pursuant to such standards, the Secretary determines that any such expenditure was not necessary for such purpose, the Secretary shall so inform the State agency of tentative exceptions taken with full explanation of such tentative exceptions. The State agency will be given a reasonable length of time to justify such expenditures. If such expenditures cannot be justified by the State agency, the total amount of expenditures actually made and incurred in such period shall be reduced by any expenditures determined by the Secretary to be not necessary in making determinations of disability authorized by this agreement. Where such total amount exceeds the amount that will be certified to the State agency as determined by the Secretary pursuant to paragraph 2, it shall be reduced as may be necessary in order to keep within the limits of Federal funds available to carry our the purposes of the Act. The amount so determined shall be certified by the Secretary to the Managing Trustee for payment to __________.[8]

4. Any monies paid to the State which are used for purposes not within the scope of this agreement shall be returned to the Treasury of the United States for deposit in the Trust Fund from which payment was certified.

5. All estimates and reports of expenditures and other reports will be prepared in accordance with appropriate budgetary and accounting methods, and administrative practice as recommended by the Secretary and agreed to by the State agency. The State agency will furnish or make available such supplemental accounts, records, or other information as are required to substantiate any estimate, expenditure, or report, as requested by the Secretary or as may be necessary for auditing purposes or to verify that expenditures were made only for purposes authorized by this agreement.

6. The State agency will comply with such standards as the Secretary may promulgate with respect to the responsibility of, and the accountability by, the State agency for property purchased by it with funds certified by the Secretary to it under this agreement.

H. *Confidential nature and limitations on use of disability determination information and records*

In accordance with standards promulgated by the Secretary, the State agency will adopt policies and procedures to insure that information contained in its records and obtained from others in connection with carrying out its disability determination functions under this agreement will be used solely for the purpose of making determinations of disability. Such information shall be disclosed only as provided in the Act and the regulations promulgated thereunder by the Secretary.

I. *Modification of agreement*

This agreement may be modified at any time by mutual consent of the partiest to the agreement.

J. *Termination by State agency*

This agreement may be terminated by the State agency on __________ advance notice in writing to the Secretary, or without such advance notice if it certifies to the Secretary and, if requested by the Secretary, such certification is accompanied by an opinion of the Attorney General of the State, that it is no longer legally able to comply substantially with any provision of this agreement.

K. *Termination by the Secretary*

The Secretary may terminate this agreement on__________advance notice in writing to the State agency. He may terminate it without such notice if he finds that he is no longer legally able to comply substantially with any provision of this agreement and so notifies the State agency in writing or, after affording an opportunity for hearing to the State agency, he finds that the State agency is no longer legally able or has failed to comply substantially with any provision of this agreement. If, under this Part or Part [illegible] this agreement is terminated, any funds paid to the State agency under Part [illegible] of this agreement which have not been expended or encumbered in accordance with the terms of this agreement prior to the date as of which the agreement was terminated, and any property purchased with funds paid to the State agency under Part G of this agreement, shall be accounted for with due regard to the equities of the parties in such funds and property.

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[8] Insert here the title of appropriate State official as under footnote 5.

L. *Effective date*

This agreement shall be effective as of ________________, and when effective, supersedes as of such date the agreement entered into between the Secretary and the State under date of ________________, and all modifications or supplements thereof.

____
(Name of State Agency)

By ______________________________

____________ ____________
(Title) (Date)

Secretary of Health, Education, and Welfare.

By ______________________________

____________ ____________
(Title) (Date)

ATTACHMENT A—MODEL AGREEMENT

1. The State agency will not discriminate against any employee or applicant for employment because of race, color, religion, sex or national origin. The State agency will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The State agency agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

2. The State agency will, in all solicitations or advertisements for employees placed by or on behalf of the State agency, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.

3. The State agency will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the agency contracting officer, advising the labor union or workers' representative of the State agency's commitments under section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

4. The State agency will comply with all provisions of Executive order No. 11246 of September 24, 1965, and of the rules and regulations, and relevant orders of the Secretary of Labor.

5. The State agency will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regu-

lations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the Secretary of Health, Education, and Welfare and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

6. In the event of the State agency's noncompliance with the nondiscrimination clauses of this contract or with any of such rules, regulations, or orders, this contract may be cancelled, terminated or suspended in whole or in part and the State agency may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of September 24, 1965, and such other sanctions may be imposed and remedies involved as provided in executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

7. The State agency will include the provisions of Paragraph (1) through (7) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The State agency will take such action with respect to any subcontract or purchase order as the Secretary of Health, Education, and Welfare may direct as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event the State agency becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Secretary of Health, Education, and Welfare, the State agency may request the United States to enter into such litigation to protect the interests of the United States.

ATTACHMENT B—MODEL AGREEMENT

(For purposes of administering title IV of the Federal Coal Mine Health and Safety Act of 1969)

This attachment when signed will constitute a supplement to the agreement entered into under Section 221 of the Social Security Act on (*Effective date of section 221 agreement*[1]), by the Secretary of Health, Education, and Welfare, and (*name of State agency*), the State agency acting on behalf of the State of (*name of State*).

1. The purpose of this supplement is to obtain the assistance of the State in connection with the administration by the Secretary of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended.

2. In any respects not inconsistent with this letter, the provisions of the foregoing Section 221 agreement shall apply to claims for "Black Lung" benefits by individuals within the State.

3. The State agency, upon request by the Secretary, will arrange for and provide such medical or other consultations or assistance as may be necessary to enable the Secretary to make proper determinations with respect to the entitlement to "Black Lung" benefits. The State agency, at such time or times and with regard to such class or classes of cases as may be mutually agreed on by the State agency and the Secretary, will also make determinations with respect to disability under the "Black Lung" program. In making determinations of disability, the State agency will apply the term "disability" in conformity with Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, the regulation issued pursuant thereto, and such standards as may be promulgated by the Secretary.

4. The State agency, upon request by the Secretary, will also provide reimbursement to a claimant for the reasonable medical expenses incurred by him in establishing his claim, such reasonable expenses not to exceed the costs of the appropriate medical examinations and tests as prescribed by Section E of the agreement and other applicable procedures and instructions promulgated by the Secretary.

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[1] If there have been modifications or supplements thereto add the phrase "as subsequently modified on (*date*)," or "as supplemented on (*date*)."

5. Payment for the necessary cost to the State agency of providing the services and reimbursements required in carrying out the terms of this supplement to the agreement between the Secretary and the State pursuant to Section 221 of the Social Security Act shall be made by the Secretary. Such payment will be made from funds appropriated for the administration of the "Black Lung" program and in accordance with the procedures and criteria in Section G of the agreement.

Accepted for the State of --------
(Name of State)

By ------------------------------

------------- -------------
(Title) (Date)

Secretary of Health, Education, and Welfare.

By ------------------------------

------------- -------------
(Title) (Date)

Alternative

3. * * * State agency and the Secretary, will also make determinations with respect to disability under the "Black Lung" program. In making determinations of disability, the State agency will apply the term "disability" in conformity with Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, the regulation issued pursuant thereto, and such standards as may be promulgated by the Secretary.

4. The State agency, upon request by the Secretary, will also provide reimbursement to a claimant for the medical expenses incurred by him for such medical examinations and tests as the Secretary may determine to be reasonable and necessary in establishing his claim. The reimbursement to a claimant for medical expenses shall not exceed the costs of such medical examinations and tests as prescribed by Section E of the agreement and other applicable procedures and instructions promulgated by the Secretary.

5. Payment for the necessary cost to the State agency of providing the services and reimbursements required in carrying out the terms of this supplement to the agreement between the Secretary and the State pursuant to Section 221 of the Social Security Act shall be made by the Secretary. Such payment will be made from funds appropriated for the administration of the "Black Lung" program and in accordance with the procedures and criteria in Section G of the agreement.

Accepted for the State of--------
(Name of State)

By ------------------------------

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(Title) (Date)

Secretary of Health, Education, and Welfare.

By ------------------------------

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(Title) (Date)

Staff question: ***Personnel Restrictions—The model State agreement states (p. 182) that "the State agency shall apply no restrictions such as a freeze on personnel hiring, a prohibition against overtime work, or other entailment of facilities needed to carry out the provisions of this agreement in a satisfactory manner, unless such restrictions are required by State law." It then states this is an optional provision. How***

many State agreements have this provision? Have State agencies been in violation of this provision?

Thirty-five States have opted for inclusion of this provision. None of the States that have opted for this provision have been in violation to our knowledge.

2. SAMPLE REVIEW AND QUALITY CONTROL

Staff question: ***Give a description of the system employed by the Bureau of Disability Insurance to assure that the State agencies implement Social Security Administration policy. Give a description of the various sampling operations which keep track of State operations. How do these devices compare with the case-by-case review in years prior to 1972? Have they contributed to more uniform administration of the program? Can you give us statistical evidence from State agency operations bearing on this? Of the 5-percent sample of initial decisions by State agency, how many are questioned by SSA? Give these (State-by-State) by allowances and denials, and indicate percentage of decisions which are ultimately changed. Give some information for reconsiderations, which we understand are on a 10-percent sample. Include description of sampling procedure to be utilized in the SSI program. Please give data on cases subject to sample review.***

A. Description of the Disability Quality Assurance Program

Title II disability claims

1. Introduction and summary

From the beginning of the disability insurance program it had been the policy of this Bureau to review all of the disability determinations made in State agencies. The object of the full review was to assure a uniform application of disability evaluation standards for all applicants in all parts of the country through detection and correction of errors in the State agency determinations.

In 1964 the Bureau of Disability Insurance (BDI) began modifying this procedure to the extent of reviewing only a sample of designated categories of determinations in which experience had shown that nearly no errors occur. All determinations in the nondesignated categories continued to be reviewed however. Beginning in June 1972, all categories of initial decisions, with limited exceptions, were subject to a sampling review only by BDI disability examiners.

The change in the review procedure was adopted to effect manpower savings, but its significance goes beyond these savings. The responsibility for preventing the effectuation of erroneous decisions was removed from the BDI reviewer and placed on the State agency examiner who makes the decision.

BDI now is pursuing a three-tiered program for monitoring quality of adjudicative results. The first tier is provided by the quality assurance units in the State agencies. These units continuously review a sample of State agency determinations, record the quality of performance and provide immediate feedback to the State agency management for corrective action; data on the quality of the Agency's performance is also forwarded to the Regional Office and to BDI's central office.

The second tier consists of the sample review conducted by disability examiners and by the Medical Consultant Staff in the BDI central office. This review provides for Federal monitoring and feedback through the regional office to the State agencies, and reflects not only the overall performance of State agencies but also the effectiveness of the State agency quality assurance units in promoting and achieving sound adjudicative results.

The third tier of the review function is the end-of-line appraisal review conducted by BDI's Division of Appraisal, and the various special reviews and program studies conducted by that Division, to monitor and evaluate the whole claims process.

2. State agency quality assurance activity

State agency quality assurance units are responsible for monitoring, on a continuing basis, the quality of all phases of the State agency claims processing. Quality assurance specialists review, on a preadjudicative basis, a continuous random sample of all types of Social Security (Title II) disability determinations selected from the daily flow of cases. Feedback to adjudicators and their supervisors on the results of this review is continuous and immediate. In addition, problem areas and developing trends detected in the review are brought to the attention of the State agency Director with recommendations for corrective action. Monthly reports on quality assurance review data are submitted to the regional and central offices for further compilation and analysis.

An important facet of the State agency quality assurance program is the clerical review of the disability determination to assure that the required information necessary for effectuation of the decision has been correctly entered by the disability examiner. The Social Security Administration's automatic data processing systems makes it essential that accurate and complete information be provided.

3. BDI quality assurance sample review

A randomly selected sample of State agency determinations in Social Security (Title II) initial and reconsideration claims is now reviewed by disability claims examiners and physician consultants in BDI's central office in Baltimore. For initial cases the sampling plan is stratified; the State agencies are grouped into seven strata according to work load size, and the proportion of cases sampled from a particular State is determined by its stratum (e.g., 50% of the cases are selected from States in the smallest work load stratum, 2% from the States in the largest work load stratum). Nationally the proportion of cases selected for the review sample averages about 5%. This plan insures a numerically large enough sample even from the smallest States to provide results which are representative. At the same time, no more cases are included in the sample from the larger States than are needed to obtain representative findings for those States.

The sample of initial claims is selected by computer as the cases arrive in Baltimore; that is, as the account number and State agency for each arriving initial case are entered into the computerized case control system; the system counts the receipt of initial cases from each State and selects every second, fiftieth, or "nth" case depending on the sampling proportion for the stratum to which the particular State is assigned.

The sample cases are reviewed by physicians on BDI's Medical Consultant Staff and by experienced disability claims examiners. These reviewers evaluate each case by the established medical and technical criteria for disability under the Social Security Act, and record data about the development procedures used and characteristics of the claims and the State agency decisions (for statistical analysis), as well as data about the reviewer's evaluation of the State agency's work.

If there is agreement with a State agency's determination, it is approved. If there is disagreement, the case is returned to the State agency along with a statement of reasons for suggesting further development or a different decision. When errors are found in the information entered on the determination form, a copy of the corrected form is returned to the State agency.

Data for each case is entered in a coded format on "quality evaluation data" (QED) forms. From the summarized and processed data, BDI's Division of Statistics and Quality Assurance analyzes and reports on the State agency's performance. Monthly reports are prepared showing significant data about the performance of individual States, regions, and the nation as a whole. (Because of the different sampling rates from State to State, all State data are appropriately weighted before summarization into regional and national results.)

Data from these reports may point to a need for instruction modifications, policy changes, or additional State agency training in particular areas. Data from the QED forms can also be used for special studies and analysis of case characteristics.

The sampling plan for Title II reconsideration cases is in a testing and experimental phase. A 10 percent sample of all State agency reconsideration determinations is now drawn in BDI based on the serial portion (last four digits) of the social security number. As reconsideration sample cases are reviewed, data about them are entered on QED forms. These data are presently being tabulated, but the system for regular analysis and reporting on reconsideration claims is not yet fully implemented.

A similar 10 percent sample review is now performed in BDI with respect to determinations of continuance in continuing disability determinations. Each of the foregoing reviews have been "on-line"; the cases are reviewed before effectuation of the allowance or cessation decision or notification to the claimant or beneficiary or a denial or continuance decision.

4. *BDI appraisal and monitoring program*

The objective of the program is to test and measure the effectiveness of the total disability claims process and of its components; appraise the effects of modifications to policies, procedures, and adjudicative systems; and to assure the integrity of results from the several case review processes.

a. *End-of-line monitoring*

End-of-line appraisal was one of BDI's earliest efforts to assess on a systematic basis the quality of the Title II initial disability determination process.

At the time all State agency determinations were reviewed in BDI, only minimal data from this review (i.e., returns and changes of decision) were tabulated. More comprehensive information was obtained from the end-of-line sample appraisal, which afforded an assessment of the quality of both the State Agency determination and the central office review. In substituting a quality assurance on-line sampling review for 100 percent review, BDI built into the system provision for comprehensive data collection on the nature of deficiencies and case characteristics with which they are associated. The end-of-line appraisal, therefore, after providing a cross-check on early Central Office sample review results, now focuses on the assessment of national trends and the overall effectiveness of policies and procedures. Its primary functions now will be to assure the integrity of the sample selection and of the data collection process and to measure the effectiveness of the quality assurance review process. It must insure that the sample is valid and must also provide confidence that changes in the adjudicative process are not caused by variation in the review system.

b. *Special case analysis studies*

As problem areas are uncovered by the end-of-line monitoring system by the on-line sampling review or by observation, special studies are conducted to more precisely define the nature of the problem and to develop means for remedying the situation. By such studies BDI attempts to determine whether problems arise because of misunderstanding or misapplication of policy or because procedures are ambiguous or incomplete.

c. *Program analysis and review*

The third major area of the BDI appraisal effort is that of program analysis and review. This area involves studies of the total integrated disability program and the relationships and interaction between its constituent parts. These studies are concerned with the effectiveness of the disability processing system or sub-systems. They differ from those studies described above in that the focus is on the process rather than on the disability determination. Such studies may draw on data collected in the on-line sampling reviews or the end-of-line monitoring systems. For other studies, onsite surveys of processing operations may be used.

B. Supplemental Security Income (SSI) Claims

Evaluation of the SSI claims process parallels evaluation for Social Security (Title II) claims except that the review is performed post-adjudicatively in the newly organized components of the DI regional offices.

The sample of initial Title XVI disability and blindness State agency determinations will be systematic and stratified. The sample cases will be selected by computer at the time the district office electronically reports movement of the case to the State agency. The sample identification is maintained in the computer control record until the State agency completes its determination and enters its decision in the system. The system then provides notification to the State agency that the completed case is a sample case and should be forwarded to the Regional Office Case Review Section.

The reviewers in the regional office communicate with the State agency concerning questioned or deficient determinations and record data on each claim reviewed. The data will be summaried, analyzed, and reported for follow through action.

The BDI end-of-line monitoring sample will provide data for analysis and evaluation of medical policy issues. SSI (Title XVI) claims included in the sample will be routed to the BDI Medical Consultant Staff for their review. The monitoring system will also yield national data for measuring the effectiveness of policies and procedures.

TABLE 27a.—*Comparison of the present on line sampling review system for social security (title II) initial State agency determinations with the former on line full review in BDI*

Former system	*Present system*
1. 100% of disability claims from the SA's were reviewed in BDI.	1. A stratified sample of approximately 5% of initial State agency determinations are reviewed in BDI and constitute the primary basis for appraising State case decision performance.
2. There was no requirement that State agencies establish their own formal, standardized system to evaluate the quality of their work. In August 1969, BDI provided guidelines for State agency systems of quality review, but not all State agencies set up a formal quality review function.	2. All State agencies have similar quality assurance programs to evaluate their own work. These programs yield information which has comparability from State agency to State agency and with BDI's review data.
3. The Medical Consultant Staff reviewed a 2% sample of all incoming initial State determinations, chiefly for purposes related to development of medical evaluation guides; in addition, the MCS was available for consultation whenever the disability evaluator needed advice, and reviewed all cases returned to State agencies for further medical development or consideration of medical factors.	3. The Medical Consultant Staff now reviews the entire review sample.
4. State agency determinations were reviewed not only for the correctness of individual case decision, but also to identify State agency problem cases and experience patterns.	4. The primary objective now is on the identification of problem areas in State agency performance and on undertaking to improve performance in those areas of evaluation or claims development where improvement is needed.
5. Feedback to the State agencies was in terms of deficiencies and error found in specific claims and general problem areas and trends.	5. State agencies still receive feedback on individual cases in the sample returned to them because of problems and errors; however, in addition, the detailed data gathered is computer-processed [illegible] as the basis for analy[illegible]ce patterns.

Results of sample case review in BDI of State ag[illegible]ility determinations

Initial cases

Returns to State agencies of sample cases questioning decision or documentation of decision have averaged about 18% of cases reviewed. Decision changes resulting from these returns have averaged about 30%–35%, for a change rate of about 6% of total State cases reviewed.[9]

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[9] STAFF NOTE.—The staff attempted to get a State-by-State breakdown of the number of decisions changed. The 6-percent figure was derived from a sample of the 5-percent sample reviewed by BDI. Information on a State-by-State basis is not available.

Reconsideration cases

Returns to State agencies of sample cases have averaged about 14% of cases reviewed. Data is now being tabulated on the rate of decision change resulting from these returns.

TABLE 28.—*Cases returned to State agencies as percent of State agency initial determinations reviewed, before introduction (fiscal years 1971 and 1972) and by month after introduction of complete sampling review*

[In percent]

	Allowances	Denials
Fiscal year 1971	6.5	3.7
Fiscal year 1972	7.3	2.6
June–August 1972	16.1	6.0
September 1972	26.5	14.4
October	25.8	15.2
November	24.2	10.4
December	16.6	5.5
January 1973	25.7	11.3
February	29.7	10.6
March	31.3	14.8
April	25.2	11.7
May	23.7	11.9
June	23.8	12.4
July	25.4	10.3
August	32.1	16.2
September	35.9	13.8
October	21.9	12.4
November	28.1	9.9
December	30.4	8.6
January 1974	31.8	14.2

The Social Security Administration states that two major qualifications need to be made about the preceding data reflecting BDI "returns" of disability determinations to State agencies.

1. *The dramatic change in experience between 1972 and 1973 reflects a major change in BDI review policies and practices rather than some abrupt change in the quality of State agency claims processing.*

For many years the BDI review process consisted of a 100% review of SA decisions by the BDI disability examiner staff and a special medical review of 2% of such decisions. The objectives of the two types of review were different, as were the skills of the reviewers and the depth of the review. Disability examiners concentrated on spotting cases where the decision appeared to be questionable rather than simply those in which the documentation was imperfect in some way. The medical review was designed to identify documentation deficiencies and to assure full medical development in this small group of cases without regard to the likelihood that such documentation would result in a change in adjudicative result. While the overall return rate was generally in the 6–7% range, the return rate for the medical sample cases was several times higher.

The 1973 data reflect a completely different review process. Disability examiners reviewed only 5% of State agency decisions and the Medical Staff reviewed 50% of this sample rather than the previous 2%. In addition, disability examiners were redirected to return all cases with documentary deficiencies, regardless of the potential effect on adjudicative result, with the objective of promoting full development of all issues to improve the quality of initial adjudication.

Thus, the change in the data reflect (a) medical review in twenty-five times as many cases, and (b) a more intensive review of the level of documentation.

2. *The bulk of the "returns" reflect differences in judgment about the adequacy of documentation rather than adjudicative "error," i.e., erroneous State agency disability decisions.*

In most cases returned to State agencies for additional documentation, the evidence secured does not affect the decision. Recent studies of the results of such returns indicate that the decision of allowance or denial is changed in only about 5% of the cases subject to sample review. Recognizing the inherent room in disability decisions for differences of judgment, this represents a very high level of quality of decision-making.

TABLE 29.—*Percentage of cases subject to sample review*

Regional offices and States	BDI for title II	Regional office for SSI
United States	5.0	8.4
Boston:		
Connecticut	10.0	11.1
Maine	20.0	33.3
Massachusetts	5.0	6.7
New Hamsphire	25.0	33.3
Rhode Island	20.0	33.3
Vermont	25.0	50.0
New York:		
New Jersey	2.5	5.3
New York	2.0	2.7
Puerto Rico	5.0	0
Philadelphia:		
Delaware:		
Vocational rehabilitation	25.0	0
Blind	----	50.0
District of Columbia	20.0	----
Maryland	5.0	33.3
Pennsylvania	2.0	9.1
Virginia	5.0	3.2
West Virginia	5.0	7.7
Atlanta:		
Alabama	5.0	20.0
Florida	2.5	10.0
Georgia	2.5	5.9
Kentucky	5.0	7.7
Mississippi	10.0	11.1
North Carolina	2.5	14.3
South Carolina:		
Vocational rehabilitation	5.0	7.1
Blind	----	12.5
Tennessee	5.0	----
Chicago:		
Illinois	2.0	9.1
Indiana	5.0	3.4
Michigan	2.0	6.7
Minnesota	10.0	4.0
Ohio	2.0	9.1
Wisconsin	5.0	3.4
Dallas:		
Arkansas	5.0	7.7
Louisiana	5.0	16.7
New Mexico	20.0	9.1
Oklahoma	10.0	25.0
Texas	2.0	14.3
Kansas City:		
Iowa	10.0	12.5
Kansas	10.0	14.3
Missouri	5.0	7.7
Nebraska	20.0	20.0
Denver:		
Colorado	10.0	14.3
Montana	25.0	33.3
North Dakota	25.0	33.3
South Dakota	25.0	33.3
Utah	25.0	25.0
Wyoming	25.0	50.0

TABLE 29.—*Percentage of cases subject to sample review*—Continued

Regional offices and States	BDI for title II	Regional office for SSI
San Francisco:		
Arizona	10.0	16.7
California	5.0	7.3
Guam	50.0	0
Hawaii	25.0	33.3
Nevada	25.0	50.0
Seattle:		
Alaska	50.0	50.0
Idaho	20.0	33.3
Oregon	10.0	16.7
Washington	5.0	10.0

NOTE.—The percentage of cases subject to Regional Office review is based on estimated workloads only. If SSA gets the estimated number of cases the sample percentage will be as indicated. It could fluctuate from month to month. The sample number is absolute. For example, for Connecticut they will start with the third case and after that select every ninth case.

Staff question: ***For the cases sampled by the Bureau of Disability Insurance in the period 1972–73 give (State-by-State) the number of allowances and denials and the percentage of each category in which the decision was changed due to the review.***

(The following data was supplied which gives this information for 2 separate months but does not show the number of cases where the decision was changed.)

SUMMARY—INITIAL CLAIMS

TABLE 30.—*Report of Social Security Administration review of State agency decision for December 1973—State agency region and Nation* [1]

Regional offices and States	Number reviewed	Number returned	Percent returned	Returns original allowed		Returns original denied	
				Number	Percent	Number	Percent
United States	30, 663	5, 890	19. 2	4, 534	30. 4	1, 356	8. 6
Boston	1, 503	283	18. 8	180	25. 2	103	13. 1
Connecticut	39	8	20. 5	3	17. 6	5	22. 7
Maine	36	11	30. 6	6	40. 0	5	23. 8
Massachusetts	34	5	14. 7	4	23. 5	1	5. 9
New Hampshire	28	3	10. 7	1	10. 0	2	11. 1
Rhode Island	21	4	19. 0	4	28. 6	0	0
Vermont	9	4	44. 4	4	80. 0	0	0
New York	4, 190	840	20. 0	740	29. 4	100	6. 0
New Jersey	23	7	30. 4	7	41. 2	0	0
New York	55	10	18. 2	8	25. 0	2	8. 7
Puerto Rico	26	3	11. 5	3	25. 0	0	0
Philadelphia	3, 445	704	20. 4	580	32. 0	124	7. 6
Delaware	20	1	5. 0	0	0	1	8. 3
District of Columbia	19	6	31. 6	4	66. 7	2	15. 4
Maryland	24	5	20. 8	4	33. 3	1	8. 3
Pennsylvania	35	7	20. 0	6	28. 6	1	7. 1
Virginia	30	6	20. 0	4	30. 8	2	11. 8
West Virginia	22	5	22. 7	5	50. 0	0	0
Atlanta	4, 302	872	20. 3	632	31. 3	240	10. 5
Alabama	38	7	18. 4	4	30. 8	3	12. 0
Florida	14	4	28. 6	3	23. 1	1	100. 0
Georgia	26	4	15. 4	3	37. 5	1	5. 6
Kentucky	23	6	26. 1	3	30. 0	3	23. 1
Mississippi	26	5	19. 2	3	30. 0	2	12. 5
North Carolina	10	1	10. 0	1	20. 0	0	0
South Carolina, I	12	4	33. 3	3	37. 5	1	25. 0
South Carolina, II	1	1	100. 0	1	100. 0	0	0
Tennessee	29	6	20. 7	6	46. 2	0	0
Chicago	7, 030	1, 520	21. 6	1, 240	35. 2	280	8. 0
Illinois	40	9	22. 5	7	30. 4	2	11. 8
Indiana	35	12	34. 3	9	47. 4	3	18. 8
Michigan	35	7	20. 0	6	46. 2	1	4. 5
Minnesota	37	9	24. 3	7	26. 9	2	18. 2
Ohio	35	7	20. 0	6	37. 5	1	5. 3
Wisconsin	23	2	8. 7	2	14. 3	0	0
Dallas	3, 855	420	10. 9	255	18. 1	165	6. 7
Arkansas	29	1	3. 4	0	0	1	3. 8
Louisiana	39	10	25. 6	7	46. 7	3	12. 5
New Mexico	35	10	28. 6	7	87. 5	3	11. 1
Oklahoma	42	5	11. 9	3	18. 8	2	7. 7
Texas	38	2	5. 3	1	5. 9	1	4. 8

See footnotes at end of table.

TABLE 30.—*Report of Social Security Administration review of State agency decision for December 1973—State agency region and Nation* [1]—Continued

Regional offices and States	Number reviewed	Number returned	Percent returned	Returns original allowed		Returns original denied	
				Number	Percent	Number	Percent
Kansas City	1, 315	265	20. 2	155	22. 1	110	17. 9
Iowa	26	6	23. 1	6	37. 5	0	0
Kansas	23	3	13. 0	2	22. 2	1	7. 1
Missouri	35	7	20. 0	3	15. 0	4	26. 7
Nebraska	25	7	28. 0	3	30. 0	4	26. 7
Denver	522	76	14. 6	52	23. 4	24	8. 0
Colorado	19	4	21. 1	2	22. 2	2	20. 0
Montana	28	3	10. 7	3	30. 0	0	0
North Dakota	12	0	0	0	0	0	0
South Dakota	11	1	9. 1	1	50. 0	0	0
Utah	19	1	5. 3	1	11. 1	1	0
Wyoming	13	4	30. 8	3	60. 0	1	12. 5
San Francisco	3, 666	766	20. 9	588	37. 5	178	8. 5
Arizona	24	2	8. 0	1	9. 1	1	7. 1
California	163	36	22. 1	28	40. 0	8	8. 6
North, I	28	10	35. 7	9	56. 3	1	8. 3
North, II	5	3	60. 0	3	75. 0	0	0
Southern area	24	5	20. 8	4	40. 0	1	7. 1
Foothill area	27	5	18. 5	3	27. 3	2	12. 5
Harbor area	20	3	15. 0	2	28. 6	1	7. 7
Central area	12	3	25. 0	2	40. 0	1	14. 3
Sacramento area	25	6	24. 0	4	33. 3	2	15. 4
Fresno area	4	0	0	0	0	0	0
San Diego area	18	1	5. 6	1	25. 0	0	0
Guam	2	1	50. 0	1	100. 0	0	0
Hawaii	27	5	18. 5	4	36. 4	1	6. 3
Nevada	11	1	9. 1	0	0	1	12. 5
Seattle	835	144	17. 2	112	25. 5	32	8. 1
Alaska	10	2	20. 0	1	20. 0	1	20. 0
Idaho	17	4	23. 5	2	20. 0	2	28. 6
Oregon	27	4	14. 8	2	16. 7	2	13. 3
Washington	23	4	17. 4	4	30. 8	0	0

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[1] Regional and national totals represent the data as it would appear if we were reviewing all cases.

TABLE 31.—*Report of BDI review of State agency decision for February 18, 1974, through March 29, 1974, State agency, region and Nation* [1]

Regional offices and States	Cases reviewed					Substantive returns					
	Allowances	Percent	Denials	Percent	Total reviewed	Allowances	Percent	Denials	Percent	Number returned	Percent returned
United States	31,664	49. 2	32,710	50. 8	64,374	8,693	27. 5	2,807	8. 6	11,500	17. 9
Boston	1,460	44. 1	1,849	55. 9	3,309	381	26. 1	237	12. 8	618	18. 7
Connecticut	30	44. 1	38	55. 9	68	7	23. 3	4	10. 5	11	16. 2
Maine	32	39. 0	50	61. 0	82	10	31. 2	4	8. 0	14	17. 1
Massachusetts	34	45. 9	40	54. 1	74	11	32. 4	6	15. 0	17	23. 0
New Hampshire	24	37. 5	40	62. 5	64	3	12. 5	10	25. 0	13	20. 3
Rhode Island	36	53. 7	31	42. 3	67	5	13. 9	1	3. 2	6	9. 0
Vermont	11	29. 7	26	70. 3	37	1	9. 1	3	11. 5	4	10. 8
New York	4,440	52. 8	3,970	47. 2	8,410	1,340	30. 2	570	14. 4	1,910	22. 7
New Jersey	27	50. 9	26	49. 1	53	8	29. 6	2	7. 7	10	18. 9
New York	58	55. 2	47	44. 8	105	18	31. 0	9	19. 1	27	25. 7
Puerto Rico	23	44. 2	29	55. 8	52	6	26. 1	2	6. 9	8	15. 4
Philadelphia	3,086	39. 1	4,799	60. 9	7,885	856	27. 7	625	13. 0	1,481	18. 8
Delaware	14	40. 0	21	60. 0	35	4	28. 6	0	0. 0	4	11. 4
District of Columbia	26	49. 1	27	50. 9	53	6	23. 1	3	11. 1	9	17. 0
Maryland	20	43. 5	26	56. 5	46	5	25. 0	2	7. 7	7	15. 2
Pennsylvania	36	41. 9	50	58. 1	86	11	30. 6	9	18. 0	20	23. 3
Virginia	21	28. 4	53	71. 6	74	3	14. 3	5	9. 4	8	10. 8
West Virginia	14	35. 9	25	64. 1	39	5	35. 7	1	4. 0	6	15. 4

See footnotes at end of table.

TABLE 31.—*Report of BDI review of State agency decision for February 18, 1974, through March 29, 1974, State agency, region, and Nation* [1]—Continued

Regional offices and States	Cases reviewed					Substantive returns					
	Allowances	Percent	Denials	Percent	Total reviewed	Allowances	Percent	Denials	Percent	Number returned	Percent returned
Atlanta	5,130	50.9	4,940	49.1	10,070	1,360	26.5	540	10.9	1,900	18.9
Albama	21	35.0	39	65.0	60	7	33.3	7	17.9	14	23.3
Florida	32	94.1	2	5.9	34	11	34.4	1	50.0	12	35.3
Georgia	18	36.0	32	64.0	50	5	27.8	4	12.5	9	18.0
Kentucky	17	25.0	51	75.0	68	4	23.5	5	9.8	9	31.2
Mississippi	41	56.2	32	43.8	73	12	29.3	2	6.3	14	19.2
North Carolina	20	52.6	18	47.4	38	3	15.0	1	5.6	4	10.5
South Carolina I	22	78.6	6	21.4	28	6	27.3	1	16.7	7	25.0
South Carolina II	2	66.7	1	33.3	3	1	50.0	0	0.0	1	33.3
Tennessee	34	53.1	30	46.9	64	6	17.6	1	3.3	7	10.9
Chicago	8,070	56.8	6,140	43.2	14,210	2,220	27.3	300	4.9	2,500	17.6
Illinois	33	55.0	27	45.0	60	7	21.2	2	7.4	9	15.0
Indiana	50	61.7	31	38.3	81	17	34.0	1	3.2	18	22.2
Michigan	29	43.3	38	56.7	67	9	31.0	3	7.9	12	17.9
Minnesota	43	59.7	29	40.3	72	6	13.6	1	3.4	7	9.7
Ohio	56	65.1	30	34.9	86	18	32.1	0	0.0	18	20.9
Wisconsin	37	60.7	24	39.3	61	5	13.5	1	4.2	6	9.8
Dallas	2,690	41.6	3,775	58.4	6,465	725	27.0	150	4.0	875	13.5
Arkansas	17	28.3	43	71.7	60	7	41.2	4	9.3	11	18.3
Louisiana	25	44.6	31	55.4	56	7	28.0	1	3.2	8	14.3
New Mexico	20	35.1	37	64.9	57	5	25.0	2	5.4	7	12.3
Oklahoma	40	44.0	51	56.0	91	12	30.0	4	7.8	16	17.6
Texas	27	45.8	32	54.2	59	6	22.2	0	0.0	6	10.2

Kansas City	1, 425	61. 2	905	38. 8	2, 330	370	26. 0	60	6. 6	430	18. 5
Iowa	39	56. 5	30	43. 5	69	9	23. 1	2	6. 7	11	15. 9
Kansas	22	44. 0	28	56. 0	50	6	27. 3	2	7. 1	8	16. 0
Missouri	32	86. 5	5	13. 5	37	9	28. 1	0	0. 0	9	24. 3
Nebraska	35	43. 8	45	56. 2	80	8	22. 9	4	8. 9	12	15. 0
Denver	564	47. 4	626	52. 6	1, 190	120	21. 3	52	8. 3	172	14. 5
Colorado	26	53. 1	23	46. 9	49	8	30. 8	4	17. 4	12	24. 5
Montana	14	36. 8	24	63. 2	38	3	21. 4	1	4. 2	4	10. 5
North Dakota	18	45. 0	22	55. 0	40	2	11. 1	1	4. 5	3	7. 5
South Dakota	16	53. 3	14	46. 7	30	1	6. 3	0	0. 0	1	3. 3
Utah	23	46. 0	27	54. 0	50	3	13. 0	0	0. 0	3	6. 0
Wyoming	5	29. 4	12	70. 6	17	1	20. 0	1	8. 3	2	11. 8
San Francisco	3, 604	42. 6	4, 858	57. 4	8, 462	1, 020	28. 3	266	5. 5	1, 286	15. 2
Arizona	18	38. 3	29	61. 7	47	4	22. 2	1	3. 4	5	10. 6
California											
Oakland	59	55. 7	47	44. 3	106	16	27. 1	2	4. 3	18	17. 0
Los Angeles	73	34. 3	140	65. 7	213	24	32. 9	6	4. 3	30	14. 1
Fresno	4	57. 1	3	42. 9	7	3	75. 0	0	0. 0	3	42. 9
Sacramento	14	51. 9	13	48. 1	27	3	21. 4	1	7. 7	4	14. 8
San Diego	14	50. 0	14	50. 0	28	1	7. 1	3	21. 4	4	14. 3
Guam	(2)		(2)		(2)	(2)		(2)		(2)	
Hawaii	11	30. 6	25	69. 4	36	2	18. 2	1	4. 0	3	8. 3
Nevada	25	43. 0	32	56. 1	57	8	32. 0	3	9. 4	11	19. 3
Seattle	1, 195	58. 5	848	41. 5	2, 043	321	26 9	7	. 8	328	16. 1
Alaska	10	71. 4	4	28. 6	14	3	30. 0	1	25. 0	4	28. 6
Idaho	23	48. 9	24	51. 1	47	5	21. 7	1	4. 2	6	12. 8
Oregon	42	72. 4	16	27. 6	58	9	21. 4	0	0	9	15. 5
Washington	32	53. 3	28	46. 7	60	10	31. 3	0	0	10	16. 7

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[1] Regional and national totals represent the data as it would appear if we were reviewing all cases.

[2] No cases were reviewed from Feb. 18, 1974 thru Mar. 29, 1974.

Staff question: ***In making the decision to go from 100% or 60% review of State agencies to a 5% sample, what studies of the review mechanism were relied upon? Please transmit any such studies, or if there were no formal studies, what body of fact or opinion was relied upon?***

When the disability program was established, BDI reviewed all decisions as to disability prepared by State Disability Determination Units (DDU's). The purpose of the review was to insure national uniformity of decision-making and to evaluate the performance of the State agencies. BDI moved away from the 100% review procedure when it became apparent that there had been a levelling off of the rate of progress of State agencies in improving the quality of their disability determinations, in an effort to devise quality assurance techniques which would be more efficient and effective. A key concept in the shift to sample review was that State agencies must accept greater responsibility for self-assessment of the quality of their work and for self-improvement based upon such assessment. It was believed that in the long run sharing this responsibility with the State agencies would produce better results than simply continuing the 100% review activity.

The reduction in review has been an evolutionary process. Over a period of two or three years, various categories of claims were identified as having a relatively low degree of risk—i.e., they were least likely to require a decision change after BDI review. The selection of categories for sampling review was based on analysis of change rate data from BDI's statistical systems. (The Commissioner's submittal of October 8, 1969, copy enclosed, discusses the changes in review policies before across-the-board sampling review was adopted.) The growing workload of initial claims, coupled with the enormous volume of work resulting from black lung legislation, and the difficulty of recruiting and training disability examiners fast enough to keep pace with the work, were factors in the timing of the decision, in 1972, to substantially reduce the review load by adopting the 5% sampling review. However, at the same time additional resources were provided to the State agencies to expand their internal quality assurance efforts. The smaller volume of review cases, stratified to ensure an adequate sampling from each State agency, would reduce the pressure on the BDI reviewers and enable them to provide total feedback on deficient cases and to achieve greater consistency in review results. In this way, more effective utilization of scarce disability evaluation manpower would be achieved, but with renewed emphasis on the importance of improvement in quality.

In summary, while the sample review approach was adopted to facilitate the further improvement of the disability claims process, the timing was considerably influenced by workload and manpower considerations.

FACE SHEET FOR COMMISSIONER'S ACTION MEETING SUBMITTAL

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
October 8, 1969.

To: Mr. Robert M. Ball, Commissioner of Social Security.
From: Bernard Popick, Director, Bureau of Disability Insurance.
Subject: Request for Approval of Reduction of 100% Review of Selected Categories of Disability Determinations.

1. Consultations:
   (a) Approved by: * * *
   (b) Nonconcurrence:
2. Informational copies sent to: All interested SSA components.
3. Discussion is not requested.
4. Recommended Action: That the Commissioner approve additional categories of disability cases which will not receive 100% review by disability examiners.
5. Reasons for Recommendations: To improve the quality of disability determinations through more effective utilization of SA and BDI manpower resources, and to reduce administrative costs.

Since 1964 CDB cases identified by State agencies as clear-cut allowances have been excluded from review in BDI. A procedure was recently implemented under which State agency disability allowances on DIB claims of workers of [illegible]ent age are receiving review by BDI disability examiners on a limited sample basis only. It has now been similarly determined that, at minimal risk of adjudicative error, State agency allowances of disabled workers in a younger group and additional childhood disability claims may also be subject to less than 100% review in BDI. As this increases State agency responsibilities for quality decision-making, we have encouraged and assisted State agencies in establishing internal quality control techniques. An in-depth review by BDI of a sample of the categories of cases that do not receive full review should also sharpen State agency development and adjudicative practices through the guidance furnished them on the sample review cases that are returned by BDI. Additionally, as BDI disability examiners are relieved of the review of these relatively clear-cut allowances they could more intensively review other cases, with a resulting feedback to the State agencies that should serve to improve the quality of the total disability product.

6. Previous Commissioner's Policy Action: None.
7. Effective Date of Recommended Action: To be effective upon approval.
8. Subsequent Steps if Approved: The necessary implementing instructions for operating personnel are being prepared. We will consult with ORS in determining the size and nature of the sample of cases to be given full review. We anticipate that the size of the quality control samples that are diverted to disability examiners and the screeinng criteria used to assure continuing review of potentially difficult cases will be modified as dictated by operating experience. The long-range plan is also to explore the feasibility of adding additional categories of cases to the less than 100% review process.

BERNARD POPICK.

Enclosures.

INTEROFFICE COMMUNICATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
October 8, 1969.

To: Mr. Robert M. Ball, Commissioner of Social Security.
From: Bernard Popick, Director, Bureau of Disability Insurance.
Subject: Request for Approval of Reduction of 100% Review of Selected Categories of Disability Determinations.

For consideration by the Commissioner

Purpose

To recommend that the Commissioner approve the selection of additional categories of State agency disability determinations that will be exempted from 100% substantive review by the Bureau of Disability Insurance. Presently, selected categories of State agency disability determinations involving childhood and older workers' disability claims are being processed with only a sample review by BDI.

Background

The Social Security Act (Section 221) provides that, subject to certain exceptions, determinations with respect to whether or not an applicant is under a disability, when such disability began and when it ceases, shall be made by an agency of the State in which he lives, under an agreement with the Secretary of Health, Education, and Welfare. The Act further provides that the Secretary may on his own motion review a State agency determination that an applicant is disabled and, as a result, determine that he is not disabled or that the disability began later, or ended earlier, than determined by the State agency.

Social Security Regulations further provide that every application for disability insurance benefits requires a determination of "period of disability" by the Administration. It should be noted here that the State agency determination is simply whether the individual has an impairment severe enough to be disabling under the law (and when it began and when it ceased). The State agency does not adjudicate whether the individual is or is not entitled to a "period of disability." Thus, even if a State agency decision is not reviewed substantively, an SSA adjudicative action is nonetheless required by the regulations.

Over the years the 100% substantive review of State agency disability determinations by BDI disability examiners has served as an effective device for insuring uniformity and consistency in the application of national policies and disability evaluation criteria, for promoting individual equity in claims decisions, for training State agency staffs, and for helping to improve the overall quality of the disability development and evaluation process.

As the program has expanded and matured, consideration has been given to the continuing need for and efficacy of 100% substantive review of State agency disability determinations, both in terms of (1) whether there are categories of cases in which State agency decisions are of such quality that 100% review is no longer required, and (2) whether a more selective review process would provide a more effective way to achieve further improvements in quality in those areas in which significant rates of deficiency continue to occur.

Status and evaluation of 100% substantive review process

Actual experience with less than 100% substantive review over a significant period of time has been limited to a group of childhood disability claims. In May 1964, BDI discontinued the review of childhood disability claims in which (1) the account was being serviced by a payment center, (2) the disability began at a pre-school age, (3) the applicant had a limited education, and (4) the applicant had never worked. This procedure was adopted to expedite the processing of these cases by enabling the State agency to send the disability material direct to the payment center rather than route it through BDI. In the payment center, a Claims Authorizer handles the adjudication of those aspects of the determination other than the disability decision. Post-adjudicative review of these "clear-cut" determinations, including some in-depth sample studies of the case folders, has substantiated the validity of the process.

Until recently, further activity in BDI related to the continuing desirability of the 100% review process was confined to a series of special studies of alternative approaches. A major study was initiated in 1965 but was interrupted by the 1965 amendments. Further studies were again interrupted by the impact of the 1967 amendments. However, in recent months it was possible to further pursue the studies initiated earlier and to supplement them with more recent data and analyses from special studies and continuing quality assessment techniques. The conclusions resulting from these efforts can be broadly summarized as follows:

(1) Viewed from the perspective of several years of program operations there has been a marked increase in the capacity of State agencies to do an effective job of disability development and evaluation and in the quality of their products. However, more remains to be done to achieve the level of quality at the initial adjudicative level to which the program should aspire, and there has been a leveling off in the rate of progress State agencies are making in that direction. Improvement in quality of documentation and evaluation at the initial adjudication level in the State agencies must remain a major program emphasis.

(2) Some categories of cases result in a much lower rate of return to the State agencies and resultant changes in decision than other categories. However, even for categories of cases with the lowest return and decision change rate, the projected value of benefit payment changes is many times the administrative costs of the review process. However, in most instances these changes in decision do not result because the earlier decision on review in BDI was considered clearly erroneous, but occur because the State agency has secured additional evidence and exercised another judgment on the evaluation issue.

Moreover, because disability evaluation guides necessarily leave substantial room for adjudicative judgment and there remain elements of subjectivity in the process, it cannot be conclusively assumed in all cases that the later decision is correct and the earlier one incorrect. In fact, in a small number of cases even more documentation at some subsequent stage in the appellate process may result in a reversal of the later decision. It has not been possible to isolate the rate of change in decision which might be characterized as "judgmental" from the rate of change resulting from more or less clear deficiency in the earlier decision. This suggests that while there is room for improvement in quality even in the categories of cases with low rates of return and decision change, the incidence of clearly erroneous decisions is extremely small. Even here, however, because of the uncertainties in assessment of the relative effects of "judgment" and "error," any reduction in review should be accompanied by steps to assure that there is no deterioration of quality of documentation and decision making.

(3) If the program is to accelerate the rate of progress in the improvement of quality, there must be greater emphasis on improved training of State agency staffs and on State agency efforts to assess and control the quality of their work. At the same time there is need to intensify the BDI substantive review in those areas in which State agencies are having the most difficulty and to do a more effective job of analysis and feedback of the results of such more intensive review. These actions would require greater resources at both the State agency and BDI levels than can be reasonably anticipated to be available within the scope of our present review operation.

(4) On balance, experience strongly indicates the best course of action at this time would be to reduce the level of BDI review in those categories of cases in which State agencies have achieved a high level of quality and redirect at least a part of the resources saved (money and manpower) to placing increased responsibility and capacity in the State agencies for improving the quality of their decisions and toward more intensive review by BDI in those categories of cases in which there is greatest need for improvement in quality. At the risk of a minimal increase in incorrect decisions in the cases not reviewed in the short run, this offers the potential for reduction in incorrect decisions in a larger group of cases, at lower administrative costs. Cases not subject to BDI substantive review of the State agency disability decisions would be routed to Claims Authorizers for adjudication of those aspects of the determination other than the disability decision.

Initiation of sample review

Based upon the considerations outlined in the preceding section, an effort has been made to identify the categories of State agency disability determinations in which it would be most feasible to reduce below 100% the review by disability examiners in BDI. Primary consideration was given to the selection of cases involving minimal risk to the disability trust fund and without unduly compromising the rights of the claimants. Experience indicated a higher rate of allowance of claims filed by individuals near retirement age and the rate of change in decision in these cases resulting from review was very small. Moreover, the risk from error for this age group if review were reduced was limited to value of one to thirty-six months of benefits depending on the months before age 65 entitlement to benefits is established.

In light of these facts, the Deputy Commissioner on March 14, 1969, approved BDI's recommendation that 100% review cases be reduced to a small control sample in most cases where the individual was age 62 or over at onset of disability. Certain categories for this age group which experience shows to involve the highest rates of incorrect decisions by State agencies continue to be subject to 100% review. Results thus far, while highly tentative suggest that the reduction of 100% review in these cases is justified.

Further extension of sample review

When we recommended reduction of 100% review of State agency allowances involving the age 62 group above, we indicated that we were giving further consideration to the identification of categories of cases in which similar steps might be taken. We now recommend that the principle of sample review be extended to additional categories of cases described below:

(1) *Older worker allowances*

Based upon additional studies of past experience and the limited recent experience in processing allowances of workers age 62 and over at onset, we now believe the age criterion ought to be reduced to age 60. The same safeguards that are now utilized in the age 62 group will be used to assure a 100% review of cases where experience shows have the highest rates of incorrect State agency decisions. At the same time, a quality control process similar to that now used for the age 62 cases will be provided for this additional age group.

(2) *More severe impairments*

There are some types of disability cases in which the disability of the individual is obvious from the severity of the impairment, e.g., loss of sight or loss of two limbs. Such cases clearly may be excluded from 100% review.

Our studies show other types of impairments which while not as obvious as the examples given represent relatively simple disability issues in terms of the result once the medical condition has been soundly established. These are cases in which not only does the State agency find that the applicant meets the criteria spelled out in the regulations for allowance on medical grounds alone, but also find that the applicant's mobility has been severely limited by his impairment. Experience shows that the rate of change in decision in these cases as the result of BDI review is relatively low. This is particularly true if the claimant is age 50 or over at onset and certain types of these cases are excluded. The rate of decision change following review for this category of cases then is less than one percent. The addition of the age factor also reduces the "risk" in terms of years of benefits payable to the claimant and his dependents.

Accordingly, we recommend that the principle of sample review be extended to those State agency worker allowances which experience shows involve the lowest rate of decision change by State agencies within the group where the claimant (1) is found to be disabled on the basis of a medical impairment which fully meets the medical criteria in the regulations, (2) is found to be of such limited mobility that he is unable to go outside without help of another person or device, and (3) is age 50 through 59 at onset of disability.

(3) *Childhood cases*

A study of childhood disability allowances was completed in 1968 after four years experience with selective review in childhood cases. The study findings reflect sound adjudicative results where the disability determination was routed without BDI review directly to the servicing payment centers under the criteria for identifying "clear-cut" childhood allowances as described above. We feel that BDI disability examiner review could aslo be discontinued without impairing program integrity by extending the process to childhood cases that are under BDI jurisdiction, i.e., cases where the parent is a disability insurance beneficiary. These will be sent directly to authorizers in BDI when the "clear-cut" criteria are met. A sample review would be used to measure the effectiveness of the process. State agency performance in the cases sent directly to servicing payment centers would be controlled by means of periodic studies.

Controlling quality

(1) *Sample review*

A major factor is the selection, review and reporting of findings by BDI on the review of a continuous sample of State agency determinations.

The principal objective here will be to provide reliable, current estimates of quality in State agency determinations that BDI is not reviewing. A system of sampling will be designed to provide information on the quality of determinations by type of case from each State agency. With this information we will be able to direct more attention to the State agencies whose work quality is falling short and less attention to State agencies who demonstrate high quality performance. We are working with ORS on the design of our system of sampling but this will take time to work out. However, upon approval of this request for reduction of 100% review, we propose to start sample review immediately by selecting a random sampling of suitable size across the board.

It should be pointed out that, as previously mentioned, the childhood cases which the State agencies send directly to the payment centers will not be subject to a continuing sample. With respect to these cases, we will continue to make occasional special studies to assess the validity of the screening criteria and the effectiveness of State agency performance.

(2) Concurrently with the expansion of sample review, we have initiated a more comprehensive program of internal quality assessment and control in the State agencies. We have completed a comprehensive State agency self-evaluation guide which is now being issued. We will be working closely with State agencies in assisting them to measure and analyze the quality of their performance and to take remedial action as called for by results. In the beginning State agencies will be urged to pay particular attention to categories of cases subject to sample review in BDI. However, the ultimate goal is to have State agencies pay more attention to the more difficult and troublesome categories of cases after they have built in an effective capacity for self evaluation. Most State agencies can take some steps in this direction within available resources. Achievement of a fully effective capacity for self-evaluation in each State agency will in time require additional resources and the achievement of this goal will be conditioned upon the availability of such resources as may be required.

(3) The long-range objective of reducing the extent of BDI substantive review is to restructure and redesign the review process to provide a more intensive, in-depth analysis of the cases which are reviewed, with expanded data collection and analytical activity to provide better feedback to State agencies on the nature and extent of deficiencies in case documentation and evaluation. While efforts to develop this different approach to initial case review will be initiated with the cases in the sample review process, the ultimate objective is to concentrate more attention on the more difficult and troublesome categories of cases and less on the "easier" categories of cases. However, the sample review process will provide a convenient laboratory for developing more effective review and analysis techniques and offer the added advantage of focusing State agency attention on the need to assure continuing special quality emphasis on categories of cases which will be subject to only limited BDI review.

Implementation

Additional procedural instructions will be required for State agencies and for several BDI work stations. Work on developing these instructions is proceeding. In addition, special messages will be required for the BDI disability examiner staff and the professional staffs of the State agencies to assure full understanding of the objectives of the sample review process. There is considerable potential for misinterpreting the intent as a deemphasis of quality and we must make special efforts to prevent this misunderstanding from developing.

Administrative impact

In total, the universe of cases which will be subject to only sample review if these recommendations are approved will be substantial. Worker allowances subject to only sample review, with the addition of the categories of cases recommended in this submittal will total about 100,000 a year. From this universe, a suitable quality control sample will be reviewed on a continuing basis. In terms of manpower, this will represent a gross reduction in disability examiner requirements of 24 man-years in 1970, which will be offset to some degree by the reduced productivity of disability examiners in handling the residue of more difficult and complex cases.

Evaluation and future direction

While we believe the steps recommended in this submittal represent a sound investment and course of action for the future to further improve the total effectiveness of the disability claims process, there is an element of "risk" involved which will require continuing evaluation of results. Reducing the level of review could cause a very small increase in the number of erroneous decisions which would otherwise have been corrected as the result of review. However, we will be alert to adjusting the quality control sample on the basis of operating experience to minimize this effect. Also, as the other quality measures described in the submittal become effective, the end result should be reduced erroneous benefit payments as well as reduced administrative costs. If the longer range trends based upon assessment of continuing experience with sample review should turn out to be adverse, adjustments may become necessary or we may have to re-evaluate the soundness of this course of action.

Assuming, however, that experience will be favorable, as we have every reason to expect, we will be working toward the identification of additional categories of cases for sample review.

Staff question: ***Please give us comments and evaluations of pre-review and post-review mechanisms with respect to sample review of DIB and SSI claims (5 percent DI initial sample and claims review section SSI sample).***

Evaluation of prereview and postreview mechanism

The Bureau of Disability Insurance (BDI) 5% quality control review of initial State agency allowance determinations in Social Security claims is made before the decision is effectuated—that is, before the claim is certified for payment. Thus, any change in the decision as a result of the review is made before notice of the determination is released. On the other hand, effectuation of the reviewed determinations takes somewhat longer to process than the unreviewed determinations. The review of initial State agency denials on Social Security claims is performed in BDI after notification. This results from a recent change in the process whereby the SA's release the denial notices to claimants before the sample cases are sent to central office for review.

Disability decisions in SSI claims are transmitted electronically by the State agencies and the award or denial notices are computer generated in the central office. As part of the same process, the review sample will be identified to the State agencies. This means that effectuation of the decision on cases in the review sample will not be delayed until the review is completed. If the review establishes an erroneous decision, appropriate action is taken promptly. Experience with this new post-decision review process will be monitored closely in weighing the relative advantages of the post vs. predecision review process.

Staff question: ***How many man-years are being spent by disability evaluators checking the 5 percent sample of State agency initial determinations? How many man-years were spent by disability evaluators checking initial determinations in fiscal years 1968 through 1972?***

Direct man-years used by disability evaluators (nonphysicians) in reviewing initial determinations[1]

Fiscal year:	*Amount*
1968	(2)
1969	(2)
1970	220
1971	214
1972	212

Direct man-years used in reviewing 5 percent sample[1]

Fiscal year:	*Amount*
1973	25
1974	25

[1] Data excludes leave and overhead allowances.

[2] Not available.

Staff question: ***Up until 1967, you were questioning more State agency denials than allowances. From 1968 on, you were questioning more and an increasing percentage of allowances. What was the reason for this change?***

It is very difficult to identify with any real precision the factors which influenced the switch-over in return experience about 1967. It was clearly not the result of any specific directed change in policy either on the part of BDI or of State agencies.

However, a number of new or evolving emphasis and directions undoubtedly contributed to subtle shifts in documentation, evaluation and review practices in the State agencies and BDI which could help to explain the shift in experience.

1. In this period, BDI was looking at its review practices and was considering moving to some form of sample review. This activity may well have had a subtle influence on review practices.

2. Prior to the 1967 amendments, there was considerable criticism of disability denials from the courts. This undoubtedly served to intensify disability reviews attention to denied claims.

3. The 1967 amendments provided legislative support for the basis for denial in BDI policies and reinforced the importance of medical documentation of allowances, undoubtedly leaving a lasting import on the review practices of disability examiners.

4. The growing numbers and percentages of cases going to reconsideration and hearing, and the growing reversal rates may have influenced State agencies to focus increasing attention on the documentation of denials, with perhaps some loss of balance in full documentation of allowances.

5. Undoubtedly the BDI lay disability examiners were somewhat reluctant to challenge an evaluation of disability by a State agency physician. As the extent of BDI Medical Staff became involved in an increasing proportion of reviewed cases, the overall review results began to approach more closely the results previously reflected in the MCS sample review process.

6. As BDI reviewers became aware of the growing costs of the program and the Congressional concern about costs, there may have been some subtle influence on the thoroughness of review of allowed claims.

7. The growth of disability workloads over the past few years has kept the State agencies, in a more or less continuing period of stress, with continuing problems of keeping a fully trained staff on board and keeping up with workloads. The disability staffs in the States may have been inclined to "cut corners" where necessary in cases in which they believed the applicant would not be disadvantaged, rather than in denials.

Whatever the precipitating factors, we believe the BDI review process has improved over the years and that the more recent experience reflects a more valid reflection of the thoroughness of documentation of both allowances and denials than the experience of a few years ago.

Staff question: ***Have sampling and quality control devices contributed to more uniform administration of the program? Can you give us statistical guidance from State agency operations bearing on this?***

We believe the sample review process, combined with the greater emphasis on and capacity for self-appraisal in the State agencies, is making a contribution toward higher quality and greater consistency in the disability determination process. However, at any given time, State agency performance is influenced by a great many variables and it is extremely difficult on a short-run basis to isolate the particular effect of each of the many variables. Since the switch to sample review and initiation of the quality appraisal function in the State agencies, there has been a vast increase in the size and scope of the program, with large attendant increases in State agency staffing, new bodies of instructions, new State agency responsibilities, and a variety of other operational developments which would tend to adversely affect State agency performance in the short-run.

Because of the interaction of the many variables affecting State agency operations, and the atypical situation the State agencies have been experiencing in the recent period, we do not believe available statistical indicators reliably reflect the impact of the switch to sample review and initiation of self-appraisal capability. Accordingly, we are unable at this time to supply statistical data which reflects the degree of improvement in uniformity of results.

Table 32 contains a listing of the states in ascending order of return rate, i.e., the position of a state in the table is determined by the return rate it experienced for the period January 1973–December 1973, those with the lowest return rate being listed first.

The first four columns of Table 32 are self-explanatory. The fifth column, labeled "Sampling Variability", gives the correction to be applied to the return rate in order to obtain approximate 95% confidence limits for the "true" percentage of defective cases in a given state. For example, Texas, with a return rate of 13.4 and a sampling variability of ±2.3, appears on the basis of 95% confidence to have between 11.1 percent and 15.7 percent of its cases questioned.

TABLE 32—*Substantive return rates for 5 percent review for period January 1973 through December 1973 ranked by State*

	Total reviewed	Total returns	Return rates	Sampling variability
United States	34, 623	7, 012	20. 3	±0. 41
Guam	10	1	10. 0	--------------
Texas	696	93	13. 4	±2. 3
Wyoming	213	29	13. 6	±4. 4
Oregon	834	117	14. 0	±2. 5
Kansas	517	74	14. 3	±3. 1
South Carolina II	28	4	14. 3	±14. 2
North Dakota	292	42	14. 4	±4. 1
Hawaii	460	67	14. 6	±3. 3
Washington	623	91	14. 6	±2. 9
Minnesota	837	129	15. 4	±2. 6
Utah	553	88	15. 9	±3. 0
South Dakota	358	58	16. 2	±3. 7
Alaska	316	53	16. 8	±4. 4
Wisconsin	573	96	16. 8	±3. 1
Delaware	465	81	17. 4	±3. 4
Maryland	535	93	17. 4	±3. 4
Iowa	684	120	17. 5	±2. 9
Massachusetts	731	129	17. 6	±2. 9
Arizona	583	104	17. 8	±3. 1
Nebraska	692	123	17. 8	±2. 9
Montana	548	98	17. 9	±3. 3
Virginia	720	133	18. 5	±2. 9
Connecticut	870	162	18. 6	±2. 3
Idaho	449	84	18. 7	±3. 7
South Carolina I	470	90	19. 1	±3. 5
Missouri	746	143	19. 2	±2. 9
Puerto Rico	511	98	19. 2	±3. 5
Arkansas	454	88	19. 4	±3. 6
West Virginia	422	84	19. 9	±4. 0
Colorado	551	110	20. 0	±3. 4
New Mexico	657	132	20. 1	±3. 2
New Hampshire	535	108	20. 2	±3. 5
California	3, 741	763	20. 4	±1. 3
Georgia	447	94	21. 0	±3. 9
Pennsylvania	799	170	21. 3	±2. 9
Louisiana	663	142	21. 4	±3. 1
Tennessee	753	161	21. 4	±3. 4
Oklahoma	895	192	21. 5	±2. 7
Illinois	651	143	22. 0	±3. 3
New Jersey	540	120	22. 2	±3. 6
Rhode Island	620	139	22. 4	±3. 4
Indiana	855	198	23. 2	±2. 9
Kentucky	612	142	23. 2	±3. 1
Michigan	652	154	23. 6	±3. 2
Maine	671	159	23. 7	±3. 2
New York	1, 206	288	23. 9	±3. 2
Florida	563	135	24. 0	±3. 5
Ohio	668	164	24. 6	±3. 3
District of Columbia	505	130	25. 7	±3. 9
North Carolina	470	121	25. 7	±3. 9
Nevada	457	120	26. 3	±3. 9
Alabama	725	197	27. 2	±3. 4
Mississippi	867	247	28. 5	±3. 0
Vermont	330	111	33. 6	±5. 5

3. REVIEW OF STATE AGENCY CASES—1966–72

1. Percent of cases questioned and returned

The following table shows return rates by States for allowed and denied cases for the years 1966 through 1970. Table 34 gives the same information for the States by region for the years 1971 and 1972.

TABLE 33.—*Percent of initial cases returned to State agencies for substantive reasons*

	1966		1967		1968		1969		1970	
	Allow	Deny	Allow	Deny	Allow	Deny	Allow	Deny	Allow	Deny
United States	5.8	8.3	5.7	7.6	6.3	5.7	6.8	5.4	7.1	4.6
Alabama	5.3	9.5	6.0	6.9	7.1	5.9	6.7	5.3	8.7	4.3
Alaska	6.7	8.7	8.0	2.0	6.4	5.3	12.3	8.5	11.3	5.3
Arizona	6.4	7.1	5.4	8.3	5.6	7.1	5.7	8.1	7.4	4.7
Arkansas	4.7	6.7	5.1	5.2	5.6	4.2	5.0	5.4	6.6	4.0
California:										
North	6.7	7.1	6.5	6.1	8.5	5.2	9.8	5.0	9.3	4.3
South	7.0	7.4	7.4	7.2	7.6	5.9	8.9	5.0	9.8	4.9
Colorado	6.1	8.2	5.8	10.3	6.0	6.7	7.0	6.3	7.9	5.5
Connecticut	7.8	9.4	8.4	8.3	8.8	7.6	10.0	7.4	10.0	6.7
Delaware:										
Vocational rehabilitation	5.8	4.4	6.3	7.6	6.3	5.9	7.0	5.3	6.4	3.8
Public welfare	12.5	10.5			19.0	28.6	4.0	0	27.3	18.8
District of Columbia	6.0	8.1	6.9	7.3	7.7	5.6	7.2	3.9	7.6	3.1
Florida	5.5	7.2	5.0	5.6	7.3	5.4	7.9	5.1	4.8	2.7
Georgia	5.8	6.2	5.6	5.9	7.2	5.2	7.3	5.2	7.6	5.0
Hawaii	6.9	9.6	6.9	8.4	6.2	3.9	6.9	3.8	7.6	2.9
Idaho	5.0	9.8	4.8	5.8	7.9	8.4	9.7	7.7	10.5	6.6
Illinois	4.9	7.9	4.5	7.7	5.5	6.3	6.4	5.3	6.6	4.8
Indiana	4.2	10.2	4.2	9.3	4.6	8.0	6.5	7.8	7.7	9.4
Iowa	4.5	5.5	4.5	7.4	4.7	4.4	5.1	3.4	7.0	3.3
Kansas	4.4	8.8	5.5	3.9	4.5	4.7	4.1	4.7	3.5	3.4
Kentucky	6.6	12.3	5.5	11.6	6.8	6.1	9.0	6.1	7.1	4.8
Louisiana	6.9	7.6	6.4	6.0	7.2	4.2	5.8	5.3	8.2	4.2
Maine	6.8	11.5	7.2	9.4	5.8	8.4	9.5	5.8	9.6	4.7
Maryland	4.3	12.5	4.3	11.1	5.9	7.1	7.5	6.3	6.7	6.2
Massachusetts	4.2	7.2	3.9	6.6	4.3	4.4	4.1	3.3	4.3	2.3
Michigan	5.2	7.0	4.9	6.4	5.8	4.2	8.4	4.8	10.4	5.4
Minnesota	5.1	10.2	4.0	9.6	4.9	6.5	3.8	6.5	4.0	4.0
Mississippi	7.5	8.0	5.8	7.0	7.7	5.1	8.3	7.4	10.5	5.9
Missouri	5.8	7.2	5.7	7.2	6.4	6.0	5.3	5.0	6.6	4.2
Montana	6.4	9.1	6.8	7.7	7.2	4.1	6.1	4.9	8.1	4.1
Nebraska	6.2	7.8	7.6	10.2	7.3	6.5	3.1	6.8	8.8	7.1
Nevada	11.4	5.6	10.1	7.3	11.9	9.0	11.4	5.8	14.1	8.7
New Hampshire	5.8	8.1	5.0	11.2	4.2	10.1	6.6	7.5	5.9	8.6
New Jersey	5.9	9.7	6.0	8.5	5.6	6.4	6.3	5.4	7.2	4.6
New Mexico	6.8	5.5	8.9	6.6	7.0	4.2	7.9	3.9	7.3	3.0
New York [1]	6.1	7.2	6.2	7.0	5.6	5.4	5.5	4.8	5.2	4.1
North Carolina [1]	4.1	6.5	4.6	8.0	6.0	5.8	6.5	5.4	5.8	4.5
North Dakota	6.6	8.1	5.6	9.6	5.7	6.1	7.5	5.7	6.8	5.4
Ohio	4.2	5.4	4.2	4.3	4.8	4.2	5.8	4.4	5.1	3.4
Oklahoma	6.7	8.6	4.8	6.0	5.9	5.0	5.0	5.0	7.3	5.3
Oregon	5.3	8.7	5.4	8.4	4.7	6.2	5.3	4.1	5.2	4.5
Pennsylvania:										
Vocational rehabilitation	5.4	11.5	6.3	10.7	7.0	7.7	6.4	6.1	5.5	5.1
Public welfare	6.1	4.5	6.7	6.2	7.8	8.0	7.0	11.2	5.5	5.1
Rhode Island	6.7	6.1	6.0	5.3	7.6	9.7	7.7	4.4	9.1	3.5
South Carolina:										
Vocational rehabilitation	5.1	6.1	4.7	5.7	4.9	4.4	5.8	5.0	5.2	3.5
Public welfare	10.9	8.6			10.5	20.0	14.6	20.8	33.3	20.0
South Dakota	6.0	10.9	4.7	10.7	5.5	6.6	3.5	4.1	5.8	3.6
Tennessee	5.7	9.6	4.6	7.8	5.8	4.9	6.9	4.2	5.3	2.7
Texas	6.4	9.7	6.2	8.9	6.1	5.8	4.8	5.3	6.3	4.1
Utah	5.8	7.0	4.5	7.4	5.3	6.0	6.0	3.5	6.8	3.0
Vermont	6.7	5.1	4.7	3.5	6.3	3.9	9.0	5.8	9.0	4.2
Virginia	5.1	7.4	6.0	9.9	5.9	6.8	6.7	6.4	5.3	5.1
Washington [1]	4.5	7.9	4.7	7.7	4.0	7.2	4.4	4.1	4.4	3.1
West Virginia	10.7	10.8	9.1	9.1	10.2	8.3	11.6	7.5	10.8	6.9
Wisconsin [2]	4.7	10.2	4.9	9.2	4.7	4.4	6.1	5.4	6.2	4.8
Wyoming	9.8	9.1	9.4	5.9	6.2	7.2	9.5	5.9	6.2	4.3
Puerto Rico	11.0	12.2	8.5	12.6	8.1	5.8	10.9	6.3	17.3	5.1
Virgin Islands										

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[1] Public welfare only.

[2] Vocational rehabilitation only.

TABLE 34.—*Initial State agency return rates, allowed and denied for substantive reason (worker, child, widow)*

Social Security region and State agency	Percent of allowances and percent of denials returned: Fiscal years—			
	1971		1972	
	Allow	Deny	Allow	Deny
United States	6. 5	3. 7	7. 3	2. 6
Boston:				
Connecticut	9. 1	4. 7	5. 5	2. 5
Maine	9. 2	4. 3	6. 3	3. 6
Massachusetts	3. 6	2. 2	3. 4	1. 3
New Hampshire	3. 7	6. 0	3. 9	6. 2
Rhode Island	8. 9	3. 8	6. 8	2. 9
Vermont	8. 7	5. 6	8. 1	3. 3
New York:				
New Jersey	6. 7	3. 5	4. 8	2. 2
New York	4. 5	4. 0	5. 5	2. 4
Puerto Rico	13. 2	4. 0	8. 4	2. 7
Virgin Islands			0	0
Philadelphia:				
Delaware:				
Vocational rehabilitation	4. 8	1. 9	. 3	2. 6
Blind	10. 5	0	0	0
District of Columbia	7. 9	3. 9	7. 9	3. 1
Maryland	6. 0	5. 1	4. 8	3. 3
Pennsylvania	5. 3	4. 4	3. 9	2. 4
Virginia	4. 9	4. 1	4. 0	2. 5
West Virginia	7. 5	4. 1	5. 8	2. 9
Atlanta:				
Alabama	7. 7	4. 1	7. 4	2. 7
Florida	4. 1	2. 1	4. 0	1. 7
Georgia	6. 2	3. 4	5. 7	2. 4
Kentucky	5. 6	4. 0	5. 0	2. 6
Mississippi	9. 3	4. 9	8. 0	2. 9
North Carolina	5. 4	4. 2	5. 3	3. 1
South Carolina:				
Vocational rehabilitation	5. 4	4. 1	3. 9	2. 3
Blind	0	8. 3	13. 6	0
Tennessee	4. 8	2. 2	4. 7	1. 7
Chicago:				
Illinois	5. 9	4. 2	4. 0	2. 1
Indiana	5. 8	3. 9	5. 6	4. 7
Michigan	7. 2	4. 2	5. 1	2. 5
Minnesota	3. 1	2. 9	2. 4	1. 4
Ohio	4. 5	2. 2	4. 8	2. 1
Wisconsin	5. 0	4. 3	4. 2	2. 1
Dallas:				
Arkansas	6. 7	4. 1	5. 4	3. 6
Louisiana	6. 8	3. 8	8. 4	2. 5
New Mexico	8. 2	3. 0	6. 6	2. 4
Oklahoma	5. 7	4. 3	4. 2	2. 1
Texas	5. 6	3. 9	4. 5	1. 0

TABLE 34.—*Initial State agency return rates, allowed and denied for substantive reason (worker, child, widow)*—Continued

Social Security region and State agency	Percent of allowances and percent of denials returned: Fiscal years— 1971 Allow	1971 Deny	1972 Allow	1972 Deny
Kansas City:				
Iowa	5.6	3.1	3.8	2.0
Kansas	4.9	2.4	2.9	2.1
Missouri	5.9	3.6	4.1	2.1
Nebraska	7.8	5.2	6.1	2.9
Denver:				
Colorado	6.5	4.0	5.0	3.3
Montana	8.6	3.7	5.4	2.8
North Dakota	6.1	3.1	5.0	3.0
South Dakota	5.1	2.5	4.7	1.4
Utah	8.3	2.5	6.6	2.3
Wyoming	7.0	4.9	3.5	4.3
California:				
Arizona	7.7	5.4	4.7	3.4
San Francisco:				
North I	10.1	3.7	7.4	2.1
North II			1.9	1.2
Southern area	8.7	3.8	6.7	2.0
Foothill area			1.7	.9
Harbor area	8.8	3.3	6.4	1.9
Central				
Guam	20.0	5.9	16.7	0
Hawaii	6.4	2.0	5.0	1.8
Nevada	10.5	4.7	7.3	3.1
Seattle:				
Alaska	10.8	6.5	5.1	2.9
Idaho	8.1	4.7	7.7	1.5
Oregon	4.1	2.7	3.7	1.4
Washington	4.3	2.6	3.9	1.2

2. *Changes in decisions of questioned cases, 1969–71*

The tables which follow show for six-month periods for the years 1969 through 1971 the number and percent of the cases which are returned to the State Agency and are ultimately changed. The last three tables also show the total number of cases questioned.

TABLE 35.—*Number and percent of initial cases returned to State agency on which State agency reverses its original decision from allow to deny (A–D) and deny to allow (D–A), January–June 1963*

	Number (A–D)	Percent	Number (D–A)	Percent
United States	3, 678	37. 0	3, 773	52. 7
Alabama	72	36. 4	91	51. 4
Alaska	4	21. 1	8	80. 0
Arizona	24	35. 3	54	52. 9
Arkansas	37	33. 3	59	56. 2
California:				
North	281	40. 5	175	55. 6
South	383	42. 6	258	51. 4
Colorado	28	39. 4	46	47. 4
Connecticut	56	35. 0	70	68. 6
Delaware:				
Vocational rehabilitation	12	42. 9	8	53. 3
Public welfare	1	33. 3	0	0
District of Columbia	24	51. 1	19	54. 3
Florida	106	31. 0	115	48. 5
Georgia	116	39. 9	102	48. 1
Hawaii	10	29. 4	8	57. 1
Idaho	7	17. 9	20	54. 1
Illinois	188	40. 4	202	58. 9
Indiana	65	34. 9	145	52. 5
Iowa	27	29. 3	18	60. 0
Kansas	13	28. 9	22	59. 4
Kentucky	73	37. 1	87	50. 6
Louisiana	74	40. 2	83	51. 2
Maine	22	30. 6	16	66. 7
Maryland	54	29. 3	67	44. 7
Massachusetts	34	27. 6	64	57. 1
Michigan	257	43. 4	153	46. 9
Minnesota	15	22. 4	42	42. 0
Mississippi	75	39. 1	73	49. 3
Missouri	75	41. 2	63	55. 3
Montana	13	29. 5	8	53. 3
Nebraska	15	23. 8	30	65. 2
Nevada	15	46. 8	11	61. 1
New Hampshire	7	25. 0	13	43. 3
New Jersey	84	30. 8	94	52. 2
New Mexico	14	29. 2	15	51. 7
New York [1]	247	35. 0	321	55. 8
North Carolina [1]	87	35. 4	77	47. 8
North Dakota	6	23. 1	13	68. 4
Ohio	147	37. 2	146	47. 9
Oklahoma [1]	44	40. 7	61	64. 9
Oregon	23	24. 7	21	36. 2
Pennsylvania:				
Vocational rehabilitation	190	37. 4	247	62. 8
Public welfare				
Rhode Island	12	18. 8	19	67. 9
South Carolina:				
Vocational rehabilitation	32	30. 8	42	40. 0
Public welfare	0	0	1	100. 0
South Dakota	10	40. 0	8	66. 7
Tennessee	99	44. 0	69	51. 1
Texas	118	34. 0	149	49. 3
Utah	11	42. 3	7	58. 3
Vermont	4	20. 0	6	54. 5
Virginia	83	38. 8	91	53. 5
Washington [1]	30	28. 6	42	54. 5
West Virginia	64	30. 2	60	42. 3
Wisconsin:				
Vocational rehabilitation	51	33. 8	54	50. 9
Public welfare				
Wyoming	4	28. 6	4	30. 8
Puerto Rico	125	48. 4	76	54. 3
Virgin Islands				

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[1] Public welfare only.

Table 36.—*Number and percent of initial cases returned to State agency on which State agency reverses its original decision from allow to deny (A–D) and deny to allow (D–A), July–December 1969*

	Number (A–D)	Percent	Number (D–A)	Percent
United States	3, 289	36. 5	2, 972	53. 6
Alabama	109	41. 6	67	55. 8
Alaska	3	30. 0	1	25. 0
Arizona	19	37. 3	36	64. 3
Arkansas	45	37. 8	37	42. 5
California:				
North	240	40. 7	117	51. 3
South	215	39. 7	169	54. 0
Los Angeles	98	51. 4	45	46. 4
Colorado	33	40. 7	46	59. 0
Connecticut	64	34. 6	40	50. 0
Delaware:				
Vocational rehabilitation	8	34. 8	4	66. 7
Public welfare	1	100. 0	0	0
District of Columbia	19	38. 0	13	61. 9
Florida	82	34. 6	73	54. 9
Georgia	74	30. 1	80	48. 2
Hawaii	8	25. 8	9	64. 3
Idaho	15	31. 3	16	57. 1
Illinois	130	33. 6	181	55. 9
Indiana	71	38. 0	153	58. 6
Iowa	39	30. 7	9	33. 3
Kansas	15	31. 9	28	57. 1
Kentucky	60	33. 7	60	46. 2
Louisiana	85	37. 3	73	57. 9
Maine	21	29. 2	17	54. 8
Maryland	51	33. 6	56	46. 7
Massachusetts	29	26. 9	34	60. 7
Michigan	205	40. 4	154	53. 8
Minnesota	15	26. 8	25	42. 4
Mississippi	81	38. 4	56	53. 3
Missouri	72	35. 6	57	55. 9
Montana	16	39. 0	8	57. 1
Nebraska	25	40. 3	29	64. 4
Nevada	16	45. 7	15	42. 9
New Hampshire	10	29. 4	15	51. 7
New Jersey	88	32. 6	96	57. 8
New Mexico	14	29. 8	13	59. 1
New York [1]	189	32. 4	200	53. 8
North Carolina [1]	65	37. 4	65	48. 1
North Dakota	4	19. 0	10	66. 7
Ohio	118	37. 5	100	49. 8
Oklahoma [1]	58	52. 7	43	50. 0
Oregon	19	29. 7	39	62. 9
Pennsylvania:				
Vocational rehabilitation	121	30. 5	187	61. 7
Public welfare				
Rhode Island	8	18. 6	3	42. 8
South Carolina:				
Vocational rehabilitation	15	20. 5	20	41. 7
Public welfare	0	0	0	0
South Dakota	8	44. 4	4	66. 7
Tennessee	61	40. 9	44	56. 4
Texas	129	35. 2	131	49. 4
Utah	6	21. 4	6	66. 7
Vermont	5	19. 2	7	41. 2
Virginia	47	32. 6	69	59. 0
Washington [1]	22	27. 8	35	50. 7
West Virginia	80	45. 7	50	52. 1
Wisconsin:				
Vocational rehabilitation	43	27. 0	52	53. 6
Public welfare				
Wyoming	5	45. 4	2	40. 0
Puerto Rico	205	53. 2	57	50. 9
Virgin Islands				

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[1] Public welfare only.

TABLE 37.—*Number and percent of initial cases returned to State agency on which State agency reverses its original decision from allow to deny (A–D) and deny to allow (D–A), January–June 1970*

	Number (A–D)	Percent	Number (D–A)	Percent
United States	2, 915	36. 1	2, 450	52. 0
Alabama	92	43. 4	43	43. 4
Alaska	0	0	0	0
Arizona	21	42. 0	23	56. 1
Arkansas	36	39. 6	31	53. 4
California:				
North	212	39. 8	129	60. 3
South	114	33. 8	83	51. 2
Los Angeles	160	39. 4	84	50. 6
Colorado	28	43. 8	30	52. 6
Connecticut	39	30. 0	42	63. 6
Delaware:				
Vocational rehabilitation	8	40. 0	3	33. 3
Public welfare	1	50. 0	1	100. 0
District of Columbia	14	42. 4	7	35. 0
Florida	60	34. 3	48	54. 5
Georgia	73	32. 9	69	45. 4
Hawaii	7	30. 4	4	66. 7
Idaho	11	31. 4	14	63. 6
Illinois	124	35. 7	120	53. 6
Indiana	82	38. 3	172	49. 4
Iowa	23	26. 4	15	60. 0
Kansas	5	19. 2	7	36. 8
Kentucky	44	30. 3	41	48. 2
Louisiana	80	41. 4	45	43. 7
Maine	14	19. 2	9	69. 2
Maryland	31	27. 7	45	44. 1
Massachusetts	35	29. 4	30	62. 5
Michigan	248	45. 5	119	47. 2
Minnesota	10	21. 7	25	59. 5
Mississippi	68	37. 2	42	49. 4
Missouri	74	36. 4	64	63. 4
Montana	16	42. 1	19	82. 6
Nebraska	24	37. 5	24	55. 8
Nevada	4	13. 3	11	57. 9
New Hampshire	6	31. 6	13	39. 4
New Jersey	104	35. 7	69	56. 1
New Mexico	14	35. 9	10	58. 8
New York [1]	212	36. 2	179	49. 7
North Carolina [1]	53	29. 9	55	45. 4
North Dakota	9	36. 0	6	66. 7
Ohio	80	29. 1	66	47. 5
Oklahoma [1]	50	45. 4	53	52. 0
Oregon	22	33. 8	26	60. 5
Pennsylvania:				
Vocational rehabilitation	96	29. 9	143	61. 6
Public welfare				
Rhode Island	15	25. 9	11	64. 7
South Carolina:				
Vocational rehabilitation	27	26. 7	29	43. 3
Public welfare	0	0	1	50. 0
South Dakota	6	31. 6	6	85. 7
Tennessee	58	38. 9	28	49. 1
Texas	128	37. 3	113	47. 9
Utah	8	28. 6	5	50. 0
Vermont	10	40. 0	3	50. 0
Virginia	35	29. 7	60	52. 6
Washington [1]	23	31. 5	29	59. 2
West Virginia	55	40. 7	43	52. 4
Wisconsin:				
Vocational rehabilitation	40	27. 8	44	49. 4
Public welfare				
Wyoming	6	50. 0	3	50. 0
Puerto Rico	110	46. 6	56	60. 2
Virgin Islands				

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[1] Public welfare only.

TABLE 38.—*Bureau review of initial State agency determinations, number and percent of allowances questioned and eventually denied: number and percent of denials questioned and eventually allowed, July–December 1970*

	Initially allowed by State agency			Initially denied by State agency		
		Cases eventually denied			Cases eventually allowed	
	Number questioned by Bureau	Number	Percent of number questioned	Number questioned by bureau	Number	Percent of number questioned
United States	9, 813	3, 646	37. 2	5, 828	3, 162	54. 3
Alabama	272	107	39. 3	171	88	51. 5
Alaska	17	6	35. 3	6	5	83. 3
Arizona	71	31	43. 7	70	37	52. 9
Arkansas	113	50	44. 2	91	42	46. 2
California:						
North	760	309	40. 7	259	141	54. 4
South	452	162	35. 8	181	99	54. 7
Los Angeles	499	204	40. 9	179	86	48. 0
Colorado	77	36	46. 8	69	34	49. 3
Connecticut	166	64	38. 6	65	40	61. 5
Delaware:						
Vocational rehabilitation	12	2	16. 7	8	7	87. 5
Public welfare	2	1	50. 0	1	0	---------
District of Columbia	53	18	34. 0	33	19	57. 6
Florida	181	69	38. 1	117	64	54. 7
Georgia	256	99	38. 7	151	79	52. 3
Hawaii	29	11	37. 9	8	6	75. 0
Idaho	52	15	28. 8	28	14	50. 0
Illinois	438	151	34. 5	254	148	58. 3
Indiana	219	75	34. 2	141	72	51. 1
Iowa	132	51	38. 6	31	15	48. 4
Kansas	56	23	41. 1	34	12	35. 3
Kentucky	131	51	38. 9	110	63	57. 3
Louisiana	233	91	39. 1	158	85	53. 8
Maine	79	22	27. 8	23	12	52. 2
Maryland	124	39	31. 5	141	68	48. 2
Massachusetts	125	31	24. 8	73	44	60. 3
Michigan	635	261	41. 1	396	224	56. 6
Minnesota	74	15	20. 3	69	40	58. 0
Mississippi	207	80	38. 6	159	84	52. 8
Missouri	207	80	38. 6	143	75	52. 4
Montana	46	22	47. 8	20	13	65. 0
Nebraska	67	30	44. 8	48	30	62. 5
Nevada	37	13	35. 1	14	6	42. 9
New Hampshire	23	8	34. 8	32	21	65. 6
New Jersey	350	131	37. 4	127	75	59. 1
New Mexico	55	30	54. 5	29	15	51. 7
New York	606	205	33. 8	443	246	55. 5
North Carolina	193	59	30. 6	170	80	47. 1
North Dakota	22	6	27. 3	5	3	60. 0
Ohio	315	105	33. 3	132	83	62. 9
Oklahoma	137	50	36. 5	135	66	48. 9
Oregon	78	30	38. 5	62	40	64. 5
Pennsylvania	409	156	38. 1	295	201	68. 1
Rhode Island	65	26	40. 0	15	11	73. 3
South Carolina:						
Vocational rehabilitation	94	29	30. 9	86	46	53. 5
Public welfare	2	---------	---------	2	1	50. 0
South Dakota	17	6	35. 3	13	8	61. 5
Tennessee	189	63	33. 3	87	49	56. 3
Texas	469	166	35. 4	377	171	45. 4
Utah	44	12	27. 3	14	5	35. 7
Vermont	22	8	34. 8	10	21	65. 6
Virginia	171	41	24. 0	127	63	49. 6
Washington	95	31	32. 6	54	24	44. 4
West Virginia	128	49	38. 3	91	55	60. 4
Wisconsin	159	59	37. 1	122	60	49. 2
Wyoming	16	3	18. 8	15	11	73. 3
Puerto Rico	289	151	52. 2	132	73	55. 3
Virgin Islands	---------	---------	---------	---------	---------	---------

TABLE 39.—*Bureau review of initial State agency determinations, number and percent of allowances questioned and eventually denied: number and percent of denials questioned and eventually allowed, January–June 1971*

	Initially allowed by State agency			Initially denied by State agency		
		Cases eventually denied			Cases eventually allowed	
	Number questioned by Bureau	Number	Percent of number questioned	Number questioned by bureau	Number	Percent of number questioned
United States	10, 544	4, 034	38. 3	6, 126	3, 080	50. 3
Alabama	250	104	41. 6	145	63	43. 4
Alaska	14	5	35. 7	10	3	30. 0
Arizona	101	50	49. 5	91	55	60. 4
Arkansas	178	75	42. 1	120	67	55. 8
California	1, 895	811	42. 8	673	339	50. 4
Colorado	92	30	32. 6	59	32	54. 2
Connecticut	173	62	35. 8	51	30	58. 8
Delaware:						
Vocational rehabilitation	29	9	31. 0	5	2	40. 0
Public welfare	1	0	0	0	0	0
District of Columbia	45	18	40. 0	23	16	69. 6
Florida	242	82	33. 9	139	68	48. 9
Georgia	279	98	35. 1	208	81	38. 9
Hawaii	24	8	33. 3	15	9	60. 0
Idaho	43	11	25. 6	19	10	52. 6
Illinois	413	148	35. 8	296	153	51. 7
Indiana	203	76	37. 4	191	99	51. 8
Iowa	122	59	48. 4	20	13	65. 0
Kansas	57	15	26. 3	42	20	47. 6
Kentucky	129	29	22. 5	136	61	44. 9
Louisiana	218	91	41. 7	151	73	48. 3
Maine	96	35	36. 5	34	21	61. 8
Maryland	153	45	29. 4	142	63	44. 4
Massachusetts	168	43	25. 6	79	38	48. 1
Michigan	534	226	42. 3	342	178	52. 0
Minnesota	65	18	27. 7	42	22	52. 4
Mississippi	211	81	38. 4	131	60	45. 8
Missouri	257	111	43. 2	101	62	61. 4
Montana	50	21	42. 0	21	12	57. 1
Nebraska	60	16	26. 7	34	19	55. 9
Nevada	35	19	54. 3	24	12	50. 0
New Hampshire	16	4	25. 0	35	16	45. 7
New Jersey	409	148	36. 2	149	85	57. 0
New Mexico	64	27	42. 2	33	20	60. 6
New York	756	259	34. 3	550	256	46. 5
North Carolina	238	81	34. 0	210	78	37. 1
North Dakota	17	5	29. 4	14	7	50. 0
Ohio	387	168	43. 4	165	75	45. 5
Oklahoma	97	43	44. 3	100	54	54. 0
Oregon	88	28	31. 8	40	26	65. 0
Pennsylvania	541	187	34. 6	369	249	67. 5
Rhode Island	86	24	27. 9	17	10	58. 8
South Carolina:						
Vocational rehabilitation	129	29	22. 5	120	44	36. 7
Public welfare	1	0	0	2	2	100. 0
South Dakota	26	12	46. 2	11	3	27. 3
Tennessee	180	77	42. 8	89	50	56. 2
Texas	415	154	37. 1	315	148	47. 0
Utah	43	14	32. 6	10	6	60. 0
Vermont	48	18	37. 5	23	11	47. 8
Virginia	148	58	39. 2	170	77	45. 3
Washington	102	40	39. 2	77	44	57. 1
West Virginia	162	60	37. 0	83	37	44. 6
Wisconsin	162	59	36. 4	82	41	50. 0
Wyoming	16	3	18. 8	7	6	85. 7
Puerto Rico	272	140	51. 5	110	53	48. 2
Virgin Islands						
Guam	4	0	0	1	1	100. 0

TABLE 40.—*Bureau review of initial State agency determinations, number and percent of allowances questioned and eventually denied: number and percent of denials questioned and eventually allowed, July–December 1971*

	Initially allowed by State agency			Initially denied by State agency		
		Cases eventually denied			Cases eventually allowed	
	Number questioned by Bureau	Number	Percent of number questioned	Number questioned by Bureau	Number	Percent of number questioned
United States	8, 695	3, 474	40. 0	4, 939	2, 591	52. 5
Alabama	321	161	50. 2	147	81	55. 1
Alaska	9	2	22. 2	8	4	50. 0
Arizona	74	36	48. 6	81	52	64. 2
Arkansas	119	38	31. 9	71	44	62. 0
California	1, 269	575	45. 3	452	223	49. 3
Colorado	80	30	37. 5	80	42	52. 5
Connecticut	172	52	30. 2	57	37	64. 9
Delaware	19	5	26. 3	13	8	61. 5
District of Columbia	60	28	46. 7	32	17	53. 1
Florida	179	60	33. 5	95	51	53. 7
Georgia	253	100	39. 5	143	68	47. 6
Hawaii	18	7	38. 9	11	8	72. 7
Idaho	36	15	41. 7	14	5	35. 7
Illinois	394	146	37. 1	260	146	52. 2
Indiana	170	51	30. 0	185	91	49. 2
Iowa	100	39	39. 0	26	19	73. 1
Kansas	41	14	34. 1	37	16	43. 2
Kentucky	118	45	38. 1	91	42	46. 2
Louisiana	226	97	42. 9	153	91	59. 5
Maine	65	30	46. 2	37	26	70. 3
Maryland	105	43	41. 0	98	47	48. 0
Massachusetts	140	41	29. 3	57	24	42. 1
Michigan	420	140	33. 3	256	134	52. 3
Minnesota	56	20	35. 7	50	23	46. 0
Mississippi	185	56	30. 3	96	40	41. 7
Missouri	212	82	38. 7	110	68	61. 8
Montana	28	11	39. 3	17	11	64. 7
Nebraska	62	31	50. 0	35	20	57. 1
Nevada	34	16	47. 1	16	10	62. 5
New Hampshire	25	10	40. 0	21	10	47. 6
New Jersey	284	120	42. 3	141	88	62. 4
New Mexico	60	32	53. 3	22	10	45. 5
New York	560	204	36. 4	340	172	50. 6
North Carolina	241	79	32. 8	209	81	38. 8
North Dakota	17	7	41. 2	8	5	62. 5
Ohio	375	148	39. 5	197	104	52. 8
Oklahoma	78	42	53. 8	64	39	60. 9
Oregon	69	32	46. 4	46	26	56. 5
Pennsylvania	458	194	42. 4	283	162	57. 2
Rhode Island	64	21	32. 8	15	9	60. 0
South Carolina:						
Vocational rehabilitation	101	39	38. 6	88	31	35. 2
Public welfare	4	3	75. 0	0	0	0
South Dakota	20	8	40. 0	7	3	42. 9
Tennessee	188	76	40. 4	76	49	64. 5
Texas	321	124	38. 6	209	98	46. 9
Utah	40	14	35. 0	13	7	53. 8
Vermont	28	12	42. 9	10	6	60. 0
Virginia	143	53	37. 1	131	74	56. 5
Washington	105	34	32. 4	54	29	53. 7
West Virginia	97	38	39. 2	72	40	55. 6
Wisconsin	164	68	41. 5	77	41	53. 2
Wyoming	7	4	57. 1	11	10	90. 9
Puerto Rico	280	140	50. 0	117	49	41. 9
Virgin Islands						
Guam	1	1	100. 0	0	0	0

STAFF NOTE.—Information was requested a number of months ago for a State-by-State breakdown of the number of cases changed for fiscal year 1973 and fiscal year 1974. The Bureau of Disability Insurance has not been able to come up with this information to date.

4. ENFORCEMENT OF PERFORMANCE STANDARDS

Staff question: ***What leverage does the Social Security Administration have in bringing low performance State agencies up to acceptable levels of operation? Please give specific examples. What action is taken if low performance continues?***

A. How SSA determines State agency performance levels

The quality and quantity of State agency operational performance is regularly monitored by SSA through ongoing observation and assessment of cumulative and continuous State agency reporting of data in various performance indices. This ongoing analysis enables SSA to not only detect the outright signs of poor performance but also to recognize the development of unfavorable trends. SSA can then take steps using various techniques to remedy the situations. A description of some of the more effective ways to improve performance levels follows.

B. State agency visits and fiscal and administrative review program

State agencies are visited regularly by central office and regional office staff. When it is clear that problems exist which have adversely affected their performance, more frequent visits are made. These visits in some cases provide enough information for SSA to recommend measures for improvement, and to the extent it is able, SSA assists the agency in accomplishing implementation of the recommendations.

When a more in-depth analysis is needed, the Fiscal and Administrative Review is the tool used. Here practically every phase of an agency's operation is examined, including its organization, personnel practices, workload controls and processing systems, training, and fiscal administration. Procedures are checked, and individual cases reviewed. The review team composed of central and regional office personnel will discuss with the agency staff its findings, and a formal report containing recommendations that are believed vital to improvement is presented to the agency. SSA monitors the implementation of the adopted recommendations.

C. Selective types of reviews

An exhaustive Fiscal and Administrative review is not always necessary. If only a particular phase of an agency's performance is not up to acceptable standards, a review restricted to the examination of that operational phase would be emphasized.

When an agency, for example, has persistently maintained over 10% of its pending cases more than 70 days from the time of receipt, SSA's review will concentrate on this aspect. Aged cases would be reviewed to determine effectiveness of case development controls and the propriety and timeliness of the agency's development practices. The review findings and SSA's recommendations would be discussed with State Agency personnel. SSA would exert what persuasion and pressures it can to have the agency effect the recommendations at the earliest time.

D. Specific measures utilized by SSA to bolster State agencies

1. Providing SA obligational authority for expenditures

When the cause for an agency's poor performance is the result of a space problem or being inadequately staffed or equipped, SSA will authorize funds for increased space or its' renovation, as well as appropriate funding for the necessary added staff and materials

2. Developing training programs for State agency personnel

To rectify poor performance due to the lack of or inadequate training of SA personnel, SSA conducts an ongoing program for the development of training resources and materials for SA use. In conjunction with the Instrux Company of New York, a self-type training course for new examiners was developed. It permits the uniform training of agency examiners with minimum involvement of other State personnel. Various types of training plans have been made available for other professional and clerical employees of State agencies.

3. Detailing Federal personnel to assist State agency

SSA details personnel from its central office or regional office staffs to SA's whose workloads become unmanageable because of unusually heavy receipt, or where agency staffing, due to its inability to fill authorized vacancies quicklys is inadequate. Under the Intergovernmental Personnel Act of 1970 (IGPA), federal personnel have been placed on temporary details of extended tenure (6 months–2 years) in various managerial and administrative positions within a State agency. (See staff question at end of section.)

4. *Issuing performance data and comprehensive management and administrative guides*

SSA periodically furnishes State agencies with reports on various workload items, such as manpower utilization and estimated obligations, workload realization and quality. These provide data by State and National figures and contribute to agency recognition of its performance compared to others pointing up areas where management attention is needed. A Workload Management Review Guide was developed by SSA to help SA management conduct a regular assessment of its operation so that areas in need of improvement can be quickly identified and corrective measures taken.

5. *Other*

SSA sets performance goals and repeatedly urges the SA's to take measures that will enable them to meet these goals. These measures include issuing guidance directives and instructional memoranda, and regular visits by SSA personnel. Issues which cannot be resolved except through intervention of State government authorities at higher levels than the disability determination units or constituent State agency, are resolved through meetings of SSA and the appropriate State officials.

Joint discussions of problems between SSA personnel and State supervisors and medical consultants are also conducted as required. The need for assuring that agencies have adequate medical documentation resources available to handle increased loads arising from legislative changes, has resulted in SSA's development of guidelines which will assist agencies in that endeavor. This effort by SSA is a continuing one.

E. Establishment of State agency control systems for quality assurance

SA's have always sought quality performance. The increasing role of the SA in adjudication and gradual phase-out from a 100% to a 5% selective type review by BDI made it necessary to institute measures for the assurance of quality within the States.

SSA helped to develop self appraisal guides for SA management's use in measuring and improving quality, when the extent of its quality appraisal (QA) apparatus was an optional affair in each State. In 1972 SSA made agency QA systems a mandatory operational function. Additional staffing authorization was provided and QA policies and guides issued in a fiscal and administrative directive.

The State agency quality assurance system provides for: (1) a required minimum sample review; (2) a 100% clerical technical review; (3) a formalized supervisory review; (4) special studies in problem areas; and (5) a self appraisal of the total operation. SSA prepares and distributes reports covering national and individual SA performance in the sample review area. In addition, SSA has devised a SA Quality Assurance Review Guide to assist both SSA and the State agency management in assessing their operation. Formal reviews of SA quality assurance operations are conducted by regional office and central office personnel. If recommendations made by SSA are not implemented and low performance by a State agency continues, higher SA authorities are contacted. In many instances this has been necessary to obtain the higher level approvals for effectuating the changes recommended for improvement. The cooperation of these higher authorities is often essential to accomplish this, e.g., obtaining governmental approval for paid overtime, etc.

F. SSA corrective action in certain State agencies

The State agencies cited below are examples of agencies in which performance levels in various operational categories were unsatisfactory for extended periods. In these agencies SSA (BDI) was required to take measures to improve SA performance.

1. Washington

For many months this agency consistently carried an excessive part of its total pending cases for more than 70 days prior to adjudication. SSA measure of satisfactory performance in this category is that at any given time no more than 10% of agency's pending load should consist of 70-day plus cases. In early calendar year 1973, the Washington agency loads persistently exceeded 15% for this category, reaching a high point of 18.6%.

BDI regional staff constantly brought this to the attention of State management personnel and made numerous visits to conduct appraisal reviews of State performance. When the causes for the high rate were identified, recommendations were made to correct the problems.

The Agency's implementation of these was regularly monitored by BDI. As a result of SSA efforts, the aged case load in Washington which had run for long times over 15%, was gradually reduced over a 12-month interval to current rate of aged cases pending ranging between 5.5 and 6.0%, a figure consistently under that of a national average.

2. Puerto Rico

For the fiscal years 1970 and 1971, the Puerto Rico agency persistently carried very high claims pending loads. At the close of fiscal year 1970 it had 7.2 weeks work pending, the highest in the nation. This figure steadily rose. At the end of fiscal year 1971 Puerto Rico had 7.7 weeks work on hand. From week to week case receipts steadily outnumbered dispositions. In July 1971 (the start of FY 1972) the agency opened operations with a pending load of 2,794 cases.

In the early part of 1971 (February-March) BDI RO staff conducted a thorough study of virtually all phases of the agency's operation for case processing. Through subsequent effectuation of the BDI recommendations stemming from the review made by BDI staff, the agency's output for the 6-month period July through December 1971 was approximately 12,000 cases compared with about 9,200 for the prior 6 months. By January 1972 its pending load was 2,237 cases, down to its lowest point in 2½ years. Its weeks work pending which had averaged in excess of 7 was in the 5-6 weeks work pending range.

In summation, SSA leverage in bringing low performance SA's up to acceptable levels occurs through regular review of SA's performance and continuing contact with the SA's.

Staff question: ***How many people are under the Intergovernmental Personnel Act of 1970 (IGPA)? How many people have been detailed to the State agencies in FY 1974?***

We do not have a record of the total number of applicants who have applied under the IGPA since its inception. However, since the start of the program, BDI and the State agencies have had a total of 12 people participate in mobility assignments under Title IV of the Intergovernmental Personnel Act of 1970.

In fiscal year '74, two Federal employees were detailed to the SA's under the IGPA.

The following supplemental IGPA information is furnished

Fiscal year	Number of assignments	Type of assignment	Method of assignment
1973	4	2 Federal employees to State agencies	On detail.
		1 Federal employee to State agency	On LWOP.
		1 State employee to Federal Gov't	On detail.
1974	8	5 State employees to Federal Gov't	On detail.
		2 Federal employees to State agencies	On detail.
		1 Federal employee to State University	On detail.
1975	Two assignments are currently being negotiated which are tentatively scheduled to begin in early F.Y. 1975. The assignments involve Federal employees to State agencies on a detail basis.		

5. HEW AUDIT AGENCY SUPERVISION

Section 221(f) of the Social Security Act provides that:

> All money paid to a State under this section shall be used solely for the purpose for which it is paid; and any money so paid which is not used for such purposes shall be returned to the Treasury of the United States for deposit in the Trust Fund.

And the agreements with the States declare in Part G, paragraph 6:

> The State agency will furnish or make available such supplementary accounts, records, or other information as are required to substantiate any estimate, expenditure, or report as requested by the Secretary, or as may be necessary for auditing purposes, or to verify that expenditures were made only for purposes authorized by this agreement.

In the Disability Insurance State Manual the scope of the audit is described in the following manner:

> As soon as practicable after the close of the fiscal year, or at other times as necessary, the Division of Grant-in-Aid Audits, of the Department of Health, Education, and Welfare, will make an audit in each State agency of the books of accounts and records pertaining to disability determinations under the old-age and survivors insurance program to determine:
>
> (1) That the State agency has properly reported its accountability for grants of Federal funds for this program.
>
> (2) That no part of any grant of Federal funds for such program was used for any purpose which was contrary to the provisions of the agreement between the Secretary of the Department of Health, Education, and Welfare and the State and to the applicable fiscal State and Federal laws and regulations and the Bureau of Old-Age and Survivors Insurance fiscal standards.
>
> (3) That the share of the Federal Government in any miscellaneous receipts was properly credited on the books of the State agency and reported to the Bureau of Old-Age and Survivors Insurance.

As to review of the medical evidence purchased, the Manual states that:

> The auditors will not review the adequacy of or the need for evidence nor will they review the disability determinations made by the State agency. When medical evidence has been purchased the auditors will determine that:
>
> (1) The action was authorized in accordance with the customary procedures of the agency,
>
> (2) The evidence was secured, and
>
> (3) In the case of medical examinations, X-rays, or laboratory tests, the expenditure was made in accordance with the fee schedule in effect for the agency.

Finally, as to items which are questioned by the Audit Agency, the Manual states:

> The State agency will be informed of any questioned items together with a full explanation of such items. The State agency will be be given a reasonable length of time to explain such expenditures. Full consideration will be given to the explanation furnished by the State agency before determination is made as to whether such expenditure was necessary.

Staff question: ***What role does the Bureau of Disability Insurance play in review of HEW Audit Agency questions or recommendations?***

BDI prepares and issues instructions and guidelines to its operational entities and State agencies for carrying out its audit responsibilities. As required, modifications and revisions are made to these guidelines.

Also, BDI each year furnishes the Audit Agency, at their request, recommendations for surveys that might benefit the Bureau.

Additionally, BDI has responsibility for effecting expeditious implementation of audit recommendations, for furnishing input to the prospective work plans of the HEW Audit Agency and quarterly input to the Secretary's stewardship reporting system on the status of outstanding recommendations. We encourage close liaison and frequent communication between our DI Regional Offices and the office of the corresponding audit agency regional audit director to facilitate the audit process, resolve issues preparatory to the issuance of final audit reports, and to create a greater awareness of the ways in which the process may not effectively meet BDI's management needs.

The Bureau Director and Deputy Bureau Director of the Bureau of Disability Insurance (BDI) are authorized by the Commissioner of SSA, via decision made in 1968, to make final determinations for SSA with regard to all questions and recommendations on HEW audit agency reports relating to State Disability Determination Units. This includes determinations on appeals by State agencies on audit exceptions, but excludes the authority to make final decisions on those appeals which involve precedential situations, or, have major (national) policy implications. SSA final determinations in these latter two situations remain reserved to the Commissioner.

The BDI authority is further delegated to the Assistant Bureau Director, Division of Field Disability Operations, BDI. To carry out this responsibility, the Assistant Bureau Director uses the services of a central office staff component and the offices of all DI Regional Representatives. These components obtain the documentation and develop the evidence needed to reconcile disagreements and permit the Bureau to render its final determination on an audit question or recommendation.

In the event that BDI concurs or disagrees with a State agency appeal of an audit exception, the Division of Field Disability Operations prepares an appropriate decision document for the Bureau Director's review and decision as to whether the facts support either waiver or sustenance of the audit exception.

Whatever the Director's decision, the State agency is then notified of the Bureau's final determination. Where the Bureau's decision is to sustain the audit recommendation, thus ruling against the agency's appeal, it advises the agency that future implementation of the decision is required. That implementation is monitored by the BDI Regional Representative's office. When there has been no appeal by the auditee and all parties to the audit are in concord with the exceptions and recommendations, BDI's notice to the auditee to indicates and informs the agency that implementation of recommendations is expected. When audit questions have been resolved and recommendations are completely implemented to the satisfaction of BDI, it informs both the auditee and the audit agency of the audit report closure.

If the audit issue involves a question that is solely within the province of the Commissioner's (SSA) authority, BDI will submit to his office all pertinent audit materials with its recommendation on the issue(s). Should it be necessary to have the matter go to arbitration between SSA and HEW audit agency, the Office of the Commissioner handles the audit. When the final resolution of audit resolved through such arbitration is accomplished, the auditee will be informed of the decision by BDI.

D. Special Areas of Emphasis

1. Denial rate

The first set of tables show State by State the number of disability determinations and the percent denied by the State Agency for the fiscal years, 1966–1973. The second set of tables group the States by their denial rates, shows the range of the rates, and gives the standard deviation. These tables cover fiscal years 1967 through 1973.

TABLE 41.—*State agency determinations in initial disability insurance beneficiary (worker) claims and percent denied—fiscal years 1966–69*

	Fiscal year 1966		Fiscal year 1967		Fiscal year 1968		Fiscal year 1969	
	Total determinations	Percent denied	Total determinations	Percent denied	Total determinations	Percent denied	Total determinations	Percent denied
United States	395, 708	38. 3	424, 826	37. 5	455, 687	39. 0	547, 565	43. 0
Alabama	9, 347	45. 0	9, 039	42. 6	9, 811	44. 8	12, 141	45. 9
Alaska	265	37. 7	313	44. 7	291	47. 4	428	35. 5
Arizona	3, 812	44. 4	3, 865	46. 5	4, 053	50. 2	4, 575	52. 9
Arkansas	5, 652	41. 0	6, 055	40. 1	6, 441	42. 6	7, 474	45. 5
California	37, 124	38. 3	49, 250	39. 2	54, 116	39. 9	65, 096	43. 5
Colorado	3, 322	44. 4	3, 908	48. 8	4, 025	46. 9	5, 630	49. 4
Connecticut	4, 320	28. 4	4, 460	27. 8	4, 933	30. 3	5, 892	37. 7
Delaware:								
Vocational rehabilitation	1, 011	37. 6	1, 088	34. 7	1, 164	35. 5	1, 319	38. 0
Public welfare	21	4. 8	20	35. 0	20	30. 0	33	9. 1
District of Columbia	1, 832	40. 9	1, 809	34. 5	2, 106	40. 4	2, 659	43. 7
Florida	14, 559	44. 4	15, 182	44. 3	15, 849	43. 9	18, 599	45. 9
Georgia	11, 822	42. 3	11, 862	41. 6	12, 403	42. 4	14, 908	46. 3
Hawaii	1, 104	43. 6	1, 137	40. 5	1, 242	41. 3	1, 723	43. 5
Idaho	1, 130	31. 9	1, 288	32. 3	1, 515	36. 7	1, 887	45. 1
Illinois	21, 835	42. 3	19, 596	38. 5	20, 887	38. 9	26, 241	43. 9
Indiana	9, 008	41. 0	9, 169	41. 1	10, 255	43. 3	13, 234	49. 0
Iowa	4, 350	33. 9	4, 452	30. 4	4, 702	30. 1	5, 371	28. 9
Kansas	3, 724	41. 5	3, 926	40. 7	4, 118	38. 9	4, 911	44. 2
Kentucky	7, 756	44. 9	7, 788	45. 4	8, 233	45. 2	9, 511	50. 6
Louisiana	8, 528	38. 9	9, 175	39. 9	9, 440	42. 6	11, 213	46. 2
Maine	1, 639	32. 2	1, 902	32. 2	1, 929	31. 2	2, 300	31. 2
Maryland	6, 003	42. 2	6, 840	39. 1	7, 883	40. 9	10, 126	46. 5
Massachusetts	9, 155	36. 1	10, 177	35. 9	10, 722	37. 6	12, 264	39. 0
Michigan	14, 659	32. 8	16, 486	31. 9	18, 184	35. 4	24, 335	43. 6
Minnesota	5, 100	36. 9	4, 613	35. 0	6, 003	38. 8	6, 639	41. 7
Mississippi	5, 833	42. 1	6, 353	39. 1	6, 578	41. 4	7, 898	44. 9
Missouri	9, 038	37. 7	10, 115	34. 6	10, 345	34. 1	11, 934	37. 6
Montana	1, 238	38. 0	1, 378	33. 9	1, 628	34. 4	1, 908	36. 6
Nebraska	2, 410	37. 9	2, 721	40. 9	2, 825	40. 2	3, 246	43. 6
Nevada	734	40. 7	847	41. 9	943	41. 8	1, 207	45. 0
New Hampshire	1, 071	30. 9	1, 221	34. 7	1, 342	32. 3	1, 471	36. 8
New Jersey	12, 285	33. 4	12, 638	30. 4	14, 830	32. 6	16, 532	36. 1
New Mexico	1, 960	41. 5	2, 174	44. 2	2, 334	43. 4	2, 711	48. 5
New York	36, 825	31. 9	[1] 41, 560	[1] 32. 2	[1] 41, 816	[1] 33. 6	[1] 49, 162	[1] 39. 0
North Carolina	11, 716	39. 2	[1] 11, 844	[1] 39. 3	[1] 12, 520	[1] 40. 4	[1] 14, 271	[1] 43. 8
North Dakota	905	29. 7	1, 008	28. 9	1, 003	34. 6	1, 295	36. 8
Ohio	17, 713	37. 1	19, 118	35. 8	20, 028	39. 8	25, 107	44. 3
Oklahoma	6, 192	40. 9	[1] 6, 705	[1] 39. 1	[1] 7, 083	[1] 46. 1	[1] 7, 634	[1] 47. 2
Oregon	4, 066	38. 1	4, 469	35. 5	4, 988	40. 1	6, 190	43. 0
Pennsylvania:								
Vocational rehabilitation	22, 508	34. 0	23, 629	31. 7	25, 775	33. 4	30, 423	38. 3
Public welfare	597	35. 0	842	34. 3	852	36. 5	----	----
Rhode Island	1, 738	28. 8	1, 780	26. 1	1, 984	27. 0	2, 381	34. 7
South Carolina:								
Vocational rehabilitation	6, 428	42. 5	6, 967	43. 3	7, 230	46. 0	8, 159	46. 9
Public welfare	60	23. 3	38	47. 4	18	22. 2	13	15. 4
South Dakota	1, 159	36. 8	1, 229	37. 8	1, 379	35. 5	1, 411	38. 2
Tennessee	9, 111	45. 6	9, 215	44. 9	9, 986	44. 2	12, 054	41. 4
Texas	20, 979	41. 3	21, 823	41. 9	21, 972	43. 4	26, 212	44. 8
Utah	1, 225	33. 4	1, 309	31. 0	1, 339	29. 1	1, 667	38. 0
Vermont	822	27. 5	879	24. 7	967	29. 9	1, 075	36. 6
Virginia	8, 643	36. 8	9, 692	41. 5	10, 338	40. 7	11, 839	45. 4
Washington	5, 656	41. 1	[1] 5, 949	[1] 38. 8	[1] 6, 636	[1] 39. 5	[1] 8, 415	[1] 43. 9
West Virginia	5, 792	35. 2	5, 758	35. 6	5, 834	41. 9	6, 547	45. 0
Wisconsin:								
Vocational rehabilitation	6, 742	32. 8	6, 930	30. 6	8, 023	32. 4	9, 024	38. 3
Public welfare	143	22. 4	133	24. 1	37	24. 3	----	----
Wyoming	603	43. 4	597	41. 0	742	38. 0	776	38. 1
Puerto Rico	4, 453	48. 1	2, 503	42. 8	3, 977	41. 9	8, 456	50. 9
Virgin Islands	----	----	1	0	1	0	----	----
Guam	----	----	----	----	9	33. 3	----	----

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[1] Public welfare only.

TABLE 42.—*State agency determinations in initial disability insurance beneficiary (worker) claims and percent denied—fiscal years 1970–73*

	Fiscal year 1970		Fiscal year 1971		Fiscal year 1972		Fiscal year 1973	
	Total determinations	Percent denied	Total determinations	Percent denied	Total determinations	Percent denied	Total determinations	Percent denied
United States	535, 564	44. 7	677, 766	48. 2	747, 954	49. 0	754, 433	47. 4
Alabama	11, [illegible]91	44. 9	14, 929	51. 5	15, 453	54. 2	16, 046	54. 5
Alaska	336	45. 2	543	58. 9	642	52. 5	695	53. 8
Arizona	4, 147	53. 1	5, 807	55. 8	6, 400	54. 0	6, 602	51. 1
Arkansas	7, 410	50. 3	9, 397	53. 6	9, 917	54. 4	10, 132	53. 0
California	62, 303	45. 3	79, 141	48. 2	82, 984	48. 0	83, 948	48. 4
Colorado	5, 036	42. 8	6, 148	52. 1	6, 268	51. 2	6, 090	49. 4
Connecticut	6, 254	37. 0	6, 898	35. 5	9, 693	37. 7	9, 217	38. 8
Delaware:								
Vocational rehabilitation	1, 255	38. 9	1, 654	44. 8	1, 915	43. 1	2, 017	46. 2
Public welfare	29	41. 4	21	23. 8				
District of Columbia	2, 853	49. 5	3, 150	51. 7	3, 679	51. 5	3, 110	54. 1
Florida	18, 526	47. 3	24, 059	49. 8	27, 427	51. 5	27, 518	49. 7
Georgia	14, 535	47. 4	19, 297	54. 1	20, 466	53. 4	19, 446	51. 0
Hawaii	1, 539	40. 9	1, 871	48. 9	2, 080	52. 7	2, 058	52. 6
Idaho	1, 774	44. 2	2, 351	45. 8	2, 644	45. 3	2, 601	47. 4
Illinois	25, 533	44. 5	31, 701	48. 9	38, 195	51. 9	35, 809	48. 9
Indiana	13, 234	47. 2	16, 299	52. 6	19, 174	54. 1	18, 027	48. 4
Iowa	5, 565	30. 7	6, 686	33. 4	7, 592	36. 8	7, 480	34. 0
Kansas	4, 668	45. 4	5, 705	49. 5	6, 005	51. 0	6, 097	47. 1
Kentucky	9, 026	49. 5	11, 642	55. 7	12, 647	57. 5	14, 895	59. 8
Louisiana	11, 178	47. 2	14, 071	50. 2	14, 470	53. 1	14, 955	53. 2
Maine	2, 648	34. 5	3, 554	42. 4	3, 804	45. 7	3, 851	46. 1
Maryland	9, 195	49. 0	10, 915	51. 3	11, 699	49. 9	12, 383	48. 0
Massachusetts	11, 954	39. 2	15, 094	39. 7	17, 153	42. 0	16, 945	44. 2
Michigan	25, 484	48. 6	33, 153	51. 7	34, 984	47. 8	34, 847	45. 9
Minnesota	6, 221	42. 8	8, 171	44. 6	9, 582	46. 7	9, 154	42. 4
Mississippi	7, 967	48. 2	10, 108	52. 1	10, 411	53. 9	10, 657	53. 0
Missouri	12, 171	40. 9	16, 103	42. 9	17, 035	45. 3	17, 062	42. 3
Montana	1, 918	40. 5	2, 248	46. 0	2, 370	46. 5	2, 521	46. 0
Nebraska	2, 959	43. 8	3, 339	47. 6	3, 904	51. 9	3, 829	46. 6
Nevada	1, 184	50. 8	1, 695	51. 3	2, 004	48. 9	1, 939	48. 8
New Hampshire	1, 717	49. 2	2, 194	47. 6	2, 213	51. 5	2, 433	54. 0
New Jersey	16, 784	37. 8	21, 265	42. 0	23, 685	42. 4	24, 138	40. 9
New Mexico	2, 568	50. 5	3, 720	57. 8	3, 803	58. 5	3, 621	57. 0
New York [1]	47, 955	42. 2	56, 899	44. 8	60, 747	42. 6	64, 546	41. 1
North Carolina [1]	14, 028	44. 2	18, 746	50. 6	19, 989	53. 6	20, 988	48. 6
North Dakota	1, 163	40. 4	1, 331	42. 7	1, 428	42. 9	1, 421	42. 8
Ohio	23, 388	42. 2	30, 755	45. 3	35, 595	44. 2	36, 077	40. 9
Oklahoma [1]	7, 806	53. 7	9, 253	62. 5	9, 900	55. 2	9, 793	53. 3
Oregon	5, 896	45. 0	7, 971	47. 8	9, 338	50. 8	9, 076	46. 1
Pennsylvania:								
Vocational rehabilitation	27, 231	38. 1	35, 283	41. 5	42, 478	46. 2	45, 077	42. 3
Public welfare								
Rhode Island	2, 260	27. 7	2, 787	34. 0	3, 104	35. 5	3, 363	38. 9
South Carolina:								
Vocational rehabilitation	8, 196	49. 4	10, 819	54. 0	11, 106	55. 4	11, 325	55. 2
Public welfare	21	47. 6	32				113	47. 8
South Dakota	1, 434	42. 7	1, 796	46. 3	1, 760	44. 9	1, 658	42. 5
Tennessee	11, 931	45. 5	15, 989	49. 9	17, 562	51. 4	16, 458	45. 4
Texas	26, 219	47. 9	33, 901	51. 6	37, 042	52. 3	36, 691	54. 0
Utah	1, 584	36. 4	1, 953	40. 6	2, 378	42. 0	2, 519	48. 0
Vermont	1, 142	35. 4	1, 385	41. 6	1, 598	44. 7	1, 613	45. 9
Virginia	11, 487	56. 6	14, 032	51. 9	16, 436	54. 0	15, 910	55. 4
Washington [1]	8, 437	42. 5	11, 335	48. 2	13, 141	51. 8	12, 849	47. 6
West Virginia	6, 223	45. 7	7, 714	47. 1	8, 751	49. 9	9, 333	54. 1
Wisconsin:								
Vocational rehabilitation	10, 358	42. 7	11, 848	42. 9	12, 933	43. 8	13, 259	39. 1
Public welfare								
Wyoming	792	47. 0	939	48. 6	982	52. 0	939	52. 9
Puerto Rico	8, 751	60. 1	10, 018	58. 2	11, 349	61. 4	11, 368	54. 5
Virgin Islands					3	66. 7	2	100. 0
Guam			51	31. 4	36	80. 6	32	40. 6

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[1] Public welfare only.

TABLE 43.—*State denial rates, number, and percent of jurisdictions by disability denial rates, fiscal years 1967–73* [1]

Denial rate	Jurisdictions	
	Number	Percent
Fiscal year 1967: National average, 37.5; range, 24.1 to 48.8; standard deviation [2] (percent) ±5.7.		
All jurisdictions	[3] 54	100.0
20 to 24.9	2	3.7
25 to 29.9	3	5.6
30 to 34.9	15	27.7
35 to 39.9	14	25.9
40 to 44.9	17	31.5
45 to 49.9	3	5.6
Fiscal year 1968: National average, 39.0; range, 27.0 to 50.2; standard deviation [2] (percent) ±5.3.		
All jurisdictions	[4] 53	100.0
25 to 29.9	3	5.7
30 to 34.9	11	20.8
35 to 39.9	13	24.5
40 to 44.9	20	37.7
45 to 49.9	5	9.4
50 to 54.9	1	1.9
Fiscal year 1969: National average, 43.0; range, 28.9 to 52.9; standard deviation [2] (percent) ± 5.1.		
All jurisdictions	[5] 52	100.0
25 to 29.9	1	1.9
30 to 34.9	2	3.9
35 to 39.9	16	30.8
40 to 44.9	15	28.8
45 to 49.9	15	28.8
50 to 54.9	3	5.8
Fiscal year 1970: National average, 44.7; range, 27.7 to 60.1; standard deviation [2] (percent) ± 6.0.		
All jurisdictions	[5] 52	100.0
25 to 29.9	1	1.9
30 to 34.9	2	3.8
35 to 39.9	7	13.5
40 to 44.9	16	30.8
45 to 49.9	19	36.5
50 to 54.9	4	7.7
55 to 59.9	2	3.8
60 to 64.9	1	1.9
Fiscal year 1971: National average, 48.2; range, 33.4 to 62.5; standard deviation [2] (percent) ± 6.0.		
All jurisdictions	[3] 52	100.0
30 to 34.9	2	3.8
35 to 39.9	2	3.8
40 to 44.9	11	21.2
45 to 49.9	16	30.8
50 to 54.9	15	28.9
55 to 59.9	5	9.6
60 to 64.9	1	1.9

See footnotes at end of table.

TABLE 43.—*State denial rates, number, and percent of jurisdictions by disability denial rates, fiscal years 1967–73* [1]—Continued

Denial rate	Jurisdictions	
	Number	Percent
Fiscal year 1972: National average, 49.0; range, 35.5 to 61.4; standard deviation [2] (percent) ± 5.5.		
All jurisdictions	[5] 52	100.0
35 to 39.9	3	5.8
40 to 44.9	10	19.2
45 to 49.9	11	21.2
50 to 54.9	23	44.2
55 to 59.9	4	7.7
60 to 64.9	1	1.9
Fiscal year 1973: National average, 47.4; range, 34.0 to 59.8; standard deviation [2] (percent) ± 5.5.		
All jurisdictions	[5] 53	100.0
30 to 23.9	1	1.9
35 to 39.9	3	5.7
40 to 44.9	9	17.0
45 to 49.9	21	39.6
50 to 54.9	15	28.3
55 to 59.9	4	7.5

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[1] Based on State agency disability determinations for disability insurance and freeze cases only.

[2] A measure of variation about the average. The larger the value of the standard deviation, the larger the amount of variation about the average.

[3] Excludes 2 jurisdictions where number of cases processed was too small for computation of reasonably reliable denial rates.

[4] Excludes 5 jurisdictions where the number of cases processed was too small for computation of reasonably reliable denial rates.

[5] Excludes 2 jurisdictions where number of cases processed was too small for computation of reasonably reliable denial rates.

2. Consultative medical examinations

Table 44 shows State by State the amount and percentage of total budget of funds spent on medical examinations and the percentage of cases where such evidence was purchased. For historical material (1961, 1966–1973) which shows the amount expended and the percentage of cases where medical evidence was purchased, see tables under A, Organization and Staffing, etc., pages 154–162.

TABLE 44.—*Selected data on State agency consultative medical examination operations for fiscal year 1973*

SSA regions and State agencies	Obligations (in thousands)		Medical examination obligation as percent of total budget	Disability cases completed		Percent of all cases requiring purchased medical evidence
	Total	Medical examination		Total	Initial determination	
United States	$92, 032. 0	$24, 885. 1	----------	1, 289, 227	932, 271	20. 9
Alabama	[illegible], 158. 3	730. 8	33. 8	29, 500	20, 452	20. 2
Alaska	125. 0	24. 5	19. 6	1, 196	836	16. 6
Arizona	719. 6	201. 2	27. 9	11, 358	8, 077	19. 9
Arkansas	844. 4	230. 8	27. 3	17, 944	12, 290	18. 2
California	10, 474. 5	1, 629. 5	15. 5	146, 501	102, 592	15. 3
Colorado	902. 5	286. 7	31. 7	10, 412	7, 439	24. 9
Connecticut	1, 047. 8	213. 1	20. 3	14, 662	11, 117	25. 4
Delaware:						
Public welfare	----------	----------	----------	----------	----------	----------
Vocational rehabilitation	312. 9	66. 2	21. 1	3, 267	2, 426	24. 8
District of Columbia	470. 9	138. 8	29. 4	6, 044	4, 325	26. 4
Florida	3, 041. 9	801. 6	26. 3	46, 607	33, 084	19. 2
Georgia	2, 294. 3	666. 6	29. 0	34, 034	24, 219	20. 1
Guam	5. 4	. 6	11. 1	59	33	23. 7
Hawaii	280. 9	36. 3	12. 9	3, 341	2, 306	15. 0
Idaho	373. 4	86. 9	23. 2	4, 640	3, 193	21. 3
Illinois	3, 706. 0	926. 7	25. 0	59, 072	43, 930	13. 9
Indiana	1, 957. 7	604. 8	30. 8	31, 105	21, 793	15. 6
Iowa	771. 3	256. 7	33. 2	12, 182	9, 163	24. 8
Kansas	728. 0	180. 0	24. 7	9, 574	7, 074	21. 0
Kentucky	2, 530. 8	1, 252. 0	49. 4	27, 357	18, 988	26. 0
Louisiana	1, 718. 8	476. 6	27. 7	28, 684	19, 823	27. 5
Maine	350. 5	80. 3	22. 9	6, 472	4, 556	20. 1
Maryland	1, 368. 2	455. 7	23. 3	20, 777	15, 198	27. 9
Massachusetts	2, 019. 4	394. 3	19. 5	27, 770	20, 706	18. 8
Michigan	4, 635. 7	1, 246. 1	26. 8	57, 180	41, 722	18. 0
Minnesota	1, 242. 2	234. 1	18. 8	15, 620	11, 372	19. 1
Mississippi	1, 091. 8	258. 0	23. 6	18, 604	12, 454	20. 4
Missouri	1, 665. 1	465. 2	27. 9	27, 260	20, 604	21. 7
Montana	284. 7	84. 5	29. 6	4, 426	3, 105	20. 2
Nebraska	379. 4	84. 4	22. 2	6, 522	4, 595	21. 1
Nevada	273. 5	47. 4	17. 3	3, 605	2, 335	11. 7
New Hampshire	190. 0	38. 2	20. 1	4, 080	2, 872	15. 1
New Jersey	2, 948. 7	740. 5	25. 1	39, 794	29, 696	23. 3
New Mexico	520. 3	172. 7	33. 1	6, 690	4, 482	23. 8
New York	8, 457. 4	1, 304. 8	15. 4	104, 565	80, 291	18. 0
North Carolina	1, 958. 3	440. 6	22. 4	35, 763	26, 296	18. 5
North Dakota	135. 3	25. 0	18. 4	2, 460	1, 802	16. 8
Ohio	4, 047. 4	1, 288. 6	31. 8	59, 259	45, 029	13. 6
Oklahoma	978. 1	308. 2	31. 5	15, 997	11, 309	24. 3
Oregon	1, 084. 3	320. 4	29. 5	15, 574	11, 021	27. 4
Pennsylvania:						
Public welfare	----------	----------	----------	----------	----------	----------
Vocational rehabilitation	6, 040. 4	2, 434. 6	40. 3	73, 763	56, 894	34. 9
Puerto Rico	1, 984. 9	810. 6	40. 8	23, 981	15, 118	55. 4
Rhode Island	356. 5	70. 2	19. 6	5, 625	4, 009	24. 7
South Carolina:						
Public welfare	7. 7	. 3	3. 8	204	158	13. 7
Vocational rehabilitation	1, 388. 7	266. 5	19. 1	20, 439	14, 238	19. 4
South Dakota	171. 0	37. 8	22. 1	2, 812	1, 948	23. 3
Tennessee	1, 760. 0	660. 5	37. 5	29, 648	20, 437	19. 1
Texas	4, 157. 6	1, 128. 3	27. 1	64, 773	46, 328	20. 6
Utah	343. 2	104. 0	30. 3	4, 395	3, 109	27. 2
Vermont	112. 5	13. 0	11. 5	2, 836	2, 019	8. 8
Virginia	2, 286. 9	763. 8	33. 3	29, 038	20, 484	20. 6
Washington	1, 523. 3	528. 1	34. 6	20, 835	15, 505	22. 3
West Virginia	2, 204. 9	958. 1	43. 4	17, 908	12, 493	30. 5
Wisconsin:						
Public welfare	----------	----------	----------	----------	----------	----------
Vocational rehabilitation	1, 493. 8	282. 9	18. 9	21, 400	15, 771	15. 5
Wyoming	105. 9	27. 0	25. 4	1, 613	1, 155	13. 0

Staff question: ***What is the basis for the general criteria that consultative examinations should be purchased in about 20 percent of the cases?***

State agency efforts to medically document SSA disability claims are directed primarily at resolving questions of onset, current severity and duration. While purchased independent consultative examinations have a definite role in the established medical documentation procedures and guidelines, they have historically been meant to be employed only when, in individual case situations, sufficient evidence of record was unavailable to adequately document a claim. There is not now, nor has there ever been, a general criteria that such examinations should be purchased in any fixed percentage of the disability cases processed by the State agencies.

The rate of consultative examination purchases has varied, in some instances substantially, from State to State and from year to year.

TABLE 44a.—*State agency consultative examination purchase rates*

	National average	Low State average	High State average
Fiscal year:			
1969	34. 5	17. 9	51. 2
1970	26. 0	14. 9	42. 0
1971	27. 8	14. 9	48. 1
1972	23. 7	12. 9	43. 5
1973	20. 9	8. 8	34. 9

Among the major reasons for these variations are: quality and availability of evidence of record; cooperativeness of medical sources and the extent to which medical evidence of record is pursued.

In those instances where evidence of record is not available or where sources refuse to provide the State agency with the medical data it possesses, there is no recourse but to purchase the type of examination(s) needed to evaluate a claimant's residual capacity to perform substantial gainful work. The extent to which the State agencies pursue evidence of record depends in part on the nature of the evidence (i.e., does it provide documentation that will be sufficient for adjudication or could not be obtained via a purchased consultative examination); the length of time it takes to get the evidence from the source (claims processing times are often adversely affected because of delays in receipt of medical evidence of record) and the source itself (some consistently provide poor or incomplete reports which do not obviate the need for a purchased examination).

The transfer to SA's of the full responsibility for medical development in claims and a continuing emphasis on utilization of existing sources of evidence to the fullest extent feasible have contributed to a substantial decline in the rate of purchase of consultative examinations in recent years.

Staff question: ***For the latest year available what percentage of cases at initial, at reconsideration, and at hearings levels involve the purchase of consultative medical examinations? Of the money expended for consultatives by the State agencies in fiscal 1973, how much was for initial, reconsideration, and hearing level cases respectively?***

Title II cases, fiscal year 1973

	Cases in which consultative examination was purchased		
Level of adjudication	As percent of cases referred to State agencies	As percent of total cases	Cost of consultative examinations
Initial	19. 3	[1] 19. 0	$13, 307, 000
Reconsideration	31. 1	30. 9	3, 948, 000
Hearing	42. 7	25. 3	992, 000
Continuing disability	21. 0	12. 2	1, 749, 000

[1] Cases with consultative examinations as percent of total cases requiring a disability determination, excluding technical denials.

The following instructions concerned with modifying the emphasis on and the criteria for purchasing consultative examinations were issued to all State agencies March 21, 1974, in Social Security Insurance Letter No. II–47.

* * * * * * *

II. GUIDES FOR EXPEDITING STATE AGENCY PROCESSING

A. Medical documentation under sequential evaluation process

Where the file already clearly documents residual functional capacity permitting a favorable decision under Regulations 1502(c) or (b), there is no need for the SA to request additional medical evidence, either by way of consultative examination or from other sources, simply to be able to determine if the medical Listings are met or equalled.

There is no intention here to lessen the documentation requirements from that which is needed to assure a sound determination. Regardless of whether the claim is ultimately adjudicated on the basis of medical evidence alone or on the basis of medical and vocationally relevant evidence, the medical evidence must establish the existence of an impairment and its severity. Medical information necessary for adjudication under regulation (b) or (c) is usually the same information that is outlined in the Listing of Impairments.

It is important therefore, if sound decision-making is to be expedited, that initial requests for medical evidence be clear about the kind of evidence needed. The timetested source of reference for essential program-related medical evidence is the Listing of Impairments. In addition to providing for the medical adjudication of the claim, the Listing of Impairments outlines virtually all of the essential medical evidence required for adjudication in most claims. Medical development practices structured around the evidence required in the Listing of Impairments prevent needless, repetitious requests for evidence.

When so developed, a finding of disability under regulation (b) or (c) does not require that we rule out the possibility that the applicant may meet or equal the Listing of Impairments. It does, however, require sufficient medical evidence to substantiate an impairment and the individual's residual functional capacity.

B. Timing development of medical evidence

The discussion in the Disability Insurance State Manual (DISM) 210 and 211, as modified by the instructions relating to the simultaneous development procedures in disability insurance letter (DIL) II–31, provides general guidelines on the timing of development of medical evidence in initial claims. The intent is that State agencies develop current medical evidence immediately unless there is a strong indication that evidence as of a later point in time is needed to reach a sound decision. The policy assures that development and adjudication are promptly initiated and completed whenever adequate information is available and thus permits as many beneficiaries as possible to be paid on a timely basis. These unstructured developmental guides permit the State agencies to exercise their professional competence and judgment on the basis of the facts in the individual case.

Inherent in the Listing of Impairments are medical documentation concepts to be applied in assessing the course of an impairment so that a valid prediction of expected duration can be made. When developing such cases, the Listing criteria should, of course, be observed. In some cases it may be advisable to obtain certain basic evidence early, even though final adjudication may need to be delayed. For example, when an individual alleges a recent heart attack, the immediate initiation of a request for hospital records would serve to expedite adjudication, even though it might be necessary to obtain current evidence at a later time from the individual's attending physician. In situations involving such impairments where other impairments co-exist, medical documentation and its timing would be pursued on the basis of all factors of the case.

The majority of claims involve impairments which by their nature are either static or progressive in their course. In such cases, documentation of severity is the principal issue since significant improvement or change for the better within 12 months of onset is unlikely. Most such cases can be documented and evaluated immediately. Unnecessary development should be avoided at all cost. For example, evidence current to the time of adjudication is often not needed, expecially where the onset impairment(s) has already been documented as being severe and it is of a chronic or progressive nature.

C. Unnecessary documentation of minimal or temporary impairments

Indications are that a larger proportion of claims where impairments are minimal are being filed under Title XVI than have been filed previously under Title II. In addition, many claimants allege multiple impairments of vague or minimal degree (e.g., nervousness, headaches, etc.).

The SA should use judgment in avoiding unnecessary medical development in these situations. Where, on the basis of the claimant's allegations and an initial report received from a treating source, it appears that the individual is suffering a slight neurosis, a slight impairment of sight or hearing, or other slight abnormality, the SA need not seek to corroborate this conclusion by scheduling a consultative examination. In multiple impairment cases, consultative examinations should not be purchased to document a slight impairment or combination of slight impairments (the degree of "nervousness" etc.), where the preponderance of evidence relating to all the impairments makes it unlikely that the condition would significantly affect the individual's capacity to work.

D. Use of State agency review physicians to perform consultative examinations

We recognize that in certain locales there may be insufficient medical resources available to perform consultative examinations or special tests or procedures. In other cases, inordinate delays are being encountered in scheduling consultative examinations and receiving reports of the examinations. To help alleviate these difficulties and to reduce processing time, the SA's may, for the present, in the exercise of its management discretion, permit their review physicians to perform consultative examinations even though the special circumstances (described in DISM 228–B) are not met. Similarly, restrictions may be relaxed on the performance of consultative examinations by physicians who are associated with SA review physicians in medical partnerships or similar relationships.

Obviously, in exercising its discretion, the SA will need to assure that such arrangements do not become self-defeating of overall objectives by reducing the physician review time that is needed on the staff of the SA. Also, the SA should exercise caution to assure that any possible appearance of conflict of interest on the part of SA staff physicians is avoided, and to take into account any potential adverse reactions from State and county medical societies.

The instruction in DISM 228–A that the physician member of the determination team disqualify himself from participating in the decision in a case where he or an associate has furnished a report remains in effect. Also, a SA review physician who participated in a prior denial or termination decision should not be asked to conduct a CE in connection with the current application, although there would be no objection to an associate doing so.

E. Securing consultative examinations by advance contract

Depending on local situations, claims loads and the availability of Consultative Examiners, the SA's should give consideration to the need for and the feasibility of securing consultative examinations on an advance basis. The potential beneficial effects of advance arrangements in terms of processing times may be considerable.

One possible approach would be to arrange for a full day's service by a consultant at some future date and upon concluding such an agreement, to begin scheduling examinations for this date. Experience should be closely monitored, and if favorable, such arrangements can be made with participating physicians at regularly scheduled intervals. Another possibility for securing consultative examinations would be for SA's to enter into, initially, one year contracts with clinics, hospitals, or laboratories to do examinations, tests and procedures for disability claimants on a priority basis.

State agencies which are able to secure agreements under either of the above possibilities should report fully on their experience to the RR, DI. If any legal questions arise as to the form of the agreements, the RR, DI will arrange for assistance from the Regional Attorney. Other questions relating to the administrative or fiscal effect of such agreements will be answered by the RR, DI or upon his referral of the problem, by Central Office.

F. Reasonable efforts to secure claimant cooperation

In certain situations, development cannot be completed without some affirmative action or information from the claimant (e.g., his treating source has failed to furnish a report on his behalf, further information about the history and treatment of his impairment is required, additional treating sources must be identified or located, he is being asked to confirm a consultative examination or a vocational assessment appointment). If the claimant does not respond to a State agency request for further development, DISM 214 provides that the SA should assume that he is unable rather than unwilling to cooperate, unless there is positive evidence to the contrary (e.g., the claimant has returned to work).

In view of the current workload situation, we suggest that the presumption that the claimant is unable to prosecute his claim not be applied during this critical period. The decision as to whether the claimant needs special assistance in complying with a development request will depend on all the facts in the case. If there is no indication in file that the claimant or his representative is unable to understand and respond to a written request, it is reasonable to assume (in the absence of evidence to the contrary) that he has received the letter and understands it. Where the claimant does not respond or cooperate after an initial letter, an attempt at a phone call and a close-out letter, the claim may be denied. Copies of the letters and reports of telephone calls should be retained in the folder.

However, if there is an indication (based on DO or SA contacts with the claimant or other evidence in file) that the claimant is unable to understand or respond to a written request and he cannot be reached by telephone, or if the telephone contact does not satisfactorily resolve the question, there should be at least one attempt at a face-to-face interview to secure his cooperation. If there is still no response or cooperation by the claimant the case may be denied after a close-out letter.

After the critical workload period is past, we will review experience under these interim guides to consider whether a change in the basic policy is warranted.

Staff question: ***Fees for Consultative Exams—the model State agreement states that the "State agency will use the same rates of payments as it uses to purchase the same service in the State program it administers" and where the service is not used in the regular program "the State agency will not bind itself to pay any fee or cost for such service which is in excess of the highest rate paid by Federal or State agencies in the State for the same or a similar type of service." How do you enforce this provision?***

Monitoring of this provision is accomplished by Administrative Manage ment Reviews held periodically in each State agency by members of BDI Regional and Central Office Staff. In addition, this area has been subject to review by HEW auditors.

* * * * * * *

3. Vocational specialist

The functions of the vocational specialist or consultant who considers the vocational aspects of disability determinations in the State Agency is described in the following material prepared by the Social Security Administration. The number of vocational specialists on duty in January in the State Agencies, and the Number of Comprehensive Vocational Assessments completed from July 1964 and September 1973 are shown in table 45. A description of the Comprehensive Vocational Assessment program is included herewith.

TABLE 45.—*State agency vocational specialist*

	Number of vocational specialists trained by BDI	Vocational specialists on duty as of January 1974[1]	Number of decisions fiscal year 1974 through February 1974	Vocational assessments completed June 1964 to September 1973
United States	243	98	895, 436	14, 111
Connecticut	2	1	10, 714	362
Maine	4	1	4, 715	3
[illegible]sachusetts	5	1	19, 777	500
[illegible] Hampshire	2	0	2, 957	9
Rhode Island	2	1	4, 045	33
Vermont	3	1	1, 953	1
New Jersey	5	1	26, 977	421
New York	11	4	69, 711	231
Puerto Rico	5	2	17, 678	55
Delaware:				
Vocational rehabilitation	2	0	2, 350	1
Blind	--------	--------	--------	0
District of Columbia	2	0	3, 878	1
Maryland	3	1	14, 590	73
Pennsylvania	5	0	52, 882	105
Virginia	3	4	21, 696	122
West Virginia	2	0	13, 433	55
Alabama	9	0	20, 754	481
Florida	16	2	32, 099	333
Georgia	9	0	26, 083	360
Kentucky	3	0	18, 555	181
Mississippi	8	0	12, 929	273
North Carolina	3	2	23, 182	154
South Carolina:				
Vocational rehabilitation	8	4	14, 061	794
Blind	--------	--------	232	2
Tennessee	5	2	21, 235	330
Illinois	5	3	41, 662	525
Indiana	5	1	21, 338	101
Michigan	11	9	40, 526	599
Minnesota	5	1	10, 369	546
Ohio	2	1	40, 256	1, 968
Wisconsin	2	3	14, 157	958
Arkansas	3	0	12, 440	62
Louisiana	2	1	19, 748	616
New Mexico	2	1	4, 995	144
Oklahoma	1	1	10, 485	14
Texas	9	18	46, 427	209
Iowa	8	1	8, 703	390
Kansas	5	1	6, 284	147
Missouri	8	4	19, 488	2, 000
Nebraska	3	2	4, 537	24
Colorado	3	1	7, 491	204
Montana	2	1	2, 952	11
North Dakota	2	1	1, 848	22
South Dakota	3	0	1, 927	21
Utah	2	1	3, 039	44
Wyoming	3	0	1, 109	3
Arizona	7	--------	7, 497	60
California[2]	19	14	96, 591	460
Hawaii	1	0	2, 170	55
Nevada	2	2	2, 766	0
Alaska	0	0	831	0
Idaho	3	0	3, 127	43
Oregon	3	2	10, 467	5
Washington	3	2	15, 224	--------

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[1] Specialists who did not report vocational specialist activity for January 1974 are not included.

[2] Total for 5 California offices are Sacramento, Oakland, Los Angeles, Fresno, and San Diego.

Function of the vocational specialist

The vocational specialist will have responsibility as a special consultant and advisor for insuring full, timely and appropriate consideration of the vocational factors of age, education, training and work experience in cases which require such consideration under the law, regulations and administrative policy instructions. The vocational specialist will serve as an advisor to other disability examiners and other staff members and consultants on cases involving difficult and complex evaluation and documentation problems. He must have knowledge of the full range of disability adjudication policies and problems, as well as familiarity with the special employment problems faced by handicapped persons in securing and performing jobs, and the types of jobs available to them. In addition he must be able to communicate his knowledge clearly and articulately in writing, so that it can be readily understood and used by other disability evaluators and reviewers in adjudicating cases, as well as by hearing examiners, Appeals Council members and the Federal Courts in their further review of appealed cases. He should be alert to the added potential value of this vocational information and documentation in facilitating the consideration of the claimant for vocational rehabilitation services.

The specific functions of the vocational specialist are described by the following activities:

1. Provide advice and guidance to disability examiners, reviewers and medical consultants in case problems to insure that cases requiring consideration of vocational factors are properly identified, developed, evaluated and documented;
2. Review, revise, as appropriate, or provide consultation and advice on rewriting or revising determinations of disability in cases involving vocational factors to insure that such determinations reflect pertinent evidence and documentation; sequential analysis; the relative probative value of all pertinent evidence; and explicit resolution of all pertinent issues, including opinion evidence; substantiation of inferences; with a resultant decision of legal integrity in conformity with administrative policies and guides;
3. Provide in appropriate cases a written vocational analysis explaining the meaning and weight to be given vocational evidence, its interaction with the medical and other evidence and its overall impact on the claimant's ability to engage in substantial gainful activity;
4. Provide guidance in determining the availability of work the claimant can do in the labor market in which the claimant can be expected to seek employment, considering the claimant's functional and vocational limitations and the geographical area within which he can reasonably be expected to market his services;
5. Serve as a resource for disability examiners, reviewers and medical consultants and others concerned with case adjudication in the proper use of special vocational reference publications and source material, such as the Dictionary of Occupational Titles and related volumes, the County Business Patterns, U.S. Census tabulations, and other sources of data on the physical and vocational requirements of jobs and of the availability of the jobs in the economy, locally and regionally;
6. Provide guidance on the proper development of evidence; undertake special development in appropriate cases with claimants, employers, personnel offices of local industries and community resources such as work evaluation centers, State employment services and vocational consultants; provide guidance and information to such resources on documentation of our specific program needs so that these resources can make the maximum contribution to the record and decision on all cases referred;
7. Assist in planning and conduct of in-service training of State agency personnel in development, evaluation and documentation of vocational factors;
8. Maintain liaison with and continuing knowledge of community resources engaged in the placement of handicapped workers in the Statewide labor market; employment patterns and practices in the area;

programs for the evaluation of the vocational capacities of the handicapped and for their placement in jobs they can do; and other related data. Assist in the planning for maximum utilization by the State agency of outside vocational resources for evaluating disability; and

9. Maintain a special record of activities and complete such special reports as may be deemed administratively desirable for on-going assessment of vocational factors activity and experience within the State agency.

Staff question: ***For the job of vocational specialist, what job qualifications and experience are needed?***

The position of vocational specialist grew out of the need to provide disability adjudicators with advice and guidance in the adjudication of the more difficult disability cases requiring consideration of the vocational factors of age, education, training, and work experience. In an effort to meet this need, the BDI Vocational Consultant Staff was established in 1966. Over the years since 1966, numerous training sessions have been held to train BDI and State agency vocational specialists who, in turn, have trained adjudicators in their respective organizations.

Vocational Specialists have always been selected on the basis of having demonstrated superior job competences as disability adjudicators, as well as their ability to communicate, both orally and in writing, in a clear and articulate manner. Upon selection, all potential specialists receive a formal training program which includes the following coverage:

(1) Function of the Vocational Specialist—State Agency and BDI; (2) Basic Concepts of the Definition of Disability—Medical and Vocational Factors; (3) Application of Vocational Factors Under Sections 404.1502(c) and (b) of the Regulations; (4) Application and Use of the Dictionary of Occupational Titles and Other Vocational Reference Publications; (5) Application of Evidentiary Concepts, Standards and Sources of Vocational Documentation in Resolving Disability Issues; (6) Use of Workshop Evaluation Centers and Vocational Consultants; (7) Practical Application in the Preparation and Writing of Vocational Analysis; and (8) Group Discussion of Vocational Issues in Disability Cases.

The primary responsibilities of the Vocational Specialist include providing oral and written advice and guidance to adjudicators to insure that cases requiring consideration of vocational factors are properly identified, developed, evaluated, and documented. This requires a thorough knowledge of various sources of data such as the Dictionary of Occupational Titles, U.S. Census Tabulations, and County Business Patterns in order to provide guidance on job requirements in terms of skills, physical demands, training, etcetera, the transferability of skills from one job to another and, the existence of jobs in the economy. The vocational specialist's duties bring him into contact with claimants, employers, work evaluation centers, personnel offices, State employment offices, and other governmental organizations. Other duties include conducting on-going training of adjudicators and special studies directed toward quality maintenance of disability decisions.

COMPREHENSIVE VOCATIONAL ASSESSMENT[10]

The State agencies process claims for disability insurance benefits under the Social Security Act. The State agencies refer applicants to evaluation facilities when a determination of disability cannot be made on medical considerations alone, and it is necessary to obtain evidence of the applicant's specific residual functional capacities and relate these to the physical and mental demands of jobs.

Referral by State agencies for a vocational evaluation is considered when: (1) Primary and usual sources of documentation of the claimant's functional and vocational capacity have not provided sufficient information for a disability determination; or (2) the case presents unusually difficult, controversial, or borderline problems which can best be resolved or clarified by the kinds of information the evaluation facility can provide. Referral to an evaluation facility should be considered when the need is not so much for more evidence, but rather for a professional evaluation of unclear or apparently conflicting information in the case.

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[10] "Expanding the Joint Use of Evaluation Facilities by Disability Determination Units and Vocational Rehabilitation," Seventh Institute on Rehabilitation Services, U.S. Department of Health, Education and Welfare, May 19–21, 1969, Publication Number (SRS) 72-25014, Information Memorandum RSA-IM-72-53 p. 1–10.

Referral to an evaluation facility is particularly valuable when inability to work is alleged because physical activity includes pain, fatigue, or other subjective symptoms. In such situations, the ability to observe and evaluate the claimant's performance in a variety of tasks for several days offers a valuable opportunity to determine more objectively what he can do functionally and vocationally.

In addition to the preceding criteria and assuming stability of impairment, guidelines for selection of cases for vocational evaluation are as follows: (1) inability to do customary work; (2) disability claim based on allegations of pain; (3) claimants under age 50 with limited skills or experience; (4) limited vocational background information; (5) claimants with loss of use of upper extremities, and (6) little or no work experience. When referring claimants to an evaluation facility or vocational consultant, optimum value from the evaluation depends in a large measure on three factors: (1) selection of source; (2) explanation to the claimant, and (3) communication with the consultant or the facility.

The state agency, in referring a claimant to an evaluation facility, sends the facility or vocational consultant copies of medical and vocational background information with an explanation of the questions requiring clarification. It should be emphasized that confidentiality of information will be maintained. Applications posing medical questions should be reviewed with the DDU medical consultant and/or the claimant's physician to obtain his opinion as to whether or not the referral is medically contraindicated.

In summary, the vocational consultant or evaluation facility personnel will interview the claimant, administer any necessary tests, and prepare a report explaining his residual functional capacities, aptitudes, and skills and relate them to the physical demands and skill requirements of work he might do. In making the evaluation, the facility or vocational consultant will rely on medical and background reports, their knowledge of the world of work, the results of tests and work sampling done, work the claimant can do and its availability in the economy, and should describe in some detail the information used in reaching these assumptions, indicating references to authorities used.

Staff question: ***According to the publication "Expanding the Joint Use of Evaluation Facilities by Disability Determination Units and Vocational Rehabilitation" some State agencies refer applicants for evaluation at separate facilities when a determination of disability cannot be made on medical considerations alone, and it is necessary to obtain evidence of the applicant's specific residual capacities and relate these to the physical and mental demands of the jobs. According to the SSA a total of 1,834 applicants were referred for such evaluation in 1969. How many State agencies are making such referrals? Is the number increasing? What alternatives are used in the absence of referral to such facilities? What is SSA policy on the use of such facilities?***

All except three (3) State agencies have participated in making referrals to workshop facilities since SSA began recommending the utilization of this evidentiary source in 1964.

The number of claimants referred for comprehensive vocational assessment after 1969 is as follows: 1970—1,574 referrals; 1971—1,676 referrals; 1972—1,426 referrals; and 1973—1,097 referrals. The decline in the number of referrals since 1971 may be attributable to the availability within the State agencies of more trained vocational specialists who were able to resolve borderline cases involving vocational issues without the need for sophisticated testing performed by the workshops.

If workshop facilities are not readily available or the claimant refuses to agree to such testing, the State agencies may request additional information from existing sources, purchase examinations by medical specialists, or rely on the best judgment of the S/A medical consultant and the vocational specialist based on the evidence of record. Based on the combined input of these medical and vocational specialists, the State agency adjudicative teams make the most realistic judgment possible as to what work, if any, a particular claimant can do.

The general policy concerning the use of workshop facilities is that referral to this source should be considered when, after the development of complete medical and vocational evidence, it is indicated that the claimant cannot be allowed or denied on medical grounds alone (Regulation 404.1502(a)), or allowed under Regulation 404.1502(c), and while he is physically and/or mentally precluded from doing his usual work, the evidence in file is borderline as to just what work, if any, the claimant could be expected to do.

3. Appeals Procedure

A. ALL LEVELS

1. PROCESSING TIME

Case processing time at various stages of administrative proceeding (1967–73).

TABLE 46.—*Median processing time in calendar days for Social Security disability cases, by type of determination: selected months*[1]

Month and year	Initial determinations[2]	Reconsideration requests		Hearing requests
		Affirmed	Reversed	
June 1967	90	87	(3)	98
December 1967	95	(3)	(3)	87
June 1968	91	(3)	(3)	92
December 1968	80	(3)	(3)	91
June 1969	63	(3)	(3)	90
December 1969	66	(3)	(3)	97
June 1970	62	62	72	106
December 1970	77	59	73	112
June 1971	88	93	70	112
December 1971	69	72	68	124
June 1972	61	71	64	142
December 1972	75	85	69	165
June 1973	68	86	71	177
November 1973	75	64	95	163
April 1974	71	74	105	163

[1] Processing time is measured from receipt of an initial application (or request for reconsideration or hearing) to disposition.

[2] Rates for initial determinations relate to State jurisdiction claims only. Beginning in June 1968, rates were determined from a 2 percent sample.

[3] Not available.

2. CONSULTATIVE (MEDICAL) EXAMINATION

Staff question: ***For the latest year available, what percentage of cases at initial, at reconsideration, and at hearings levels involve the purchase of consultative medical examinations? Of the money expended for consultatives by the State agencies in fiscal 1973, how much was for initial, reconsideration, and hearing level cases, respectively?***

TABLE 47.—*Social security (title II) cases fiscal year 1973*

Level of adjudication	Cases in which consultative examination was purchased		Cost of consultative examinations
	As percent of cases referred to State agencies	As percent of total cases	
Initial	19. 3	[1] 19. 0	$13, 307, 000
Reconsideration	31. 1	30. 9	3, 948, 000
Hearing	42. 7	25. 3	992, 000
Continuing disability	21. 0	12. 2	1, 749, 000

[1] Cases with consultative examinations as percent of total cases requiring a disability determination, excluding technical denials.

B. Reconsideration

1. DESCRIPTION OF PROCESS

Staff question: ***What are the roles of the State Agency, regional and central offices of the Social Security Administration in the reconsideration process for Social Security and Supplemental Security Income disability benefits?***

State Agency (SA) Role in the Reconsideration Process

Title II—Disability Insurance

Upon receipt of a folder containing a request for reconsideration, the State agency first examines the evidence of record to determine whether additional information is necessary. If information concerning the vocational background is needed, the SA arranges for development of this evidence with the assistance of the district office, through a personal contact with the claimant or by arranging for a special vocational rehabilitation work shop evaluation. When the medical evidence needs clarification, expanding or updating, the State agency is responsible for obtaining this information from treating sources or by means of a purchased consultative examination. After all development has been completed, the SA evaluates the evidence and prepares a determination. The folder with the determination is then sent to the Bureau of Disability Insurance for final action on the claim.

Title XVI—Supplemental Security Income

The State agency's role on reconsideration of SSI claims embraces the review, development and determination preparation described for Title II claims

An additional SA responsibility in SSI claims is designating the notice to be sent to the claimant. The SA alerts the central office computer system as to whether the claim is allowed or denied, and if denied, provides the basis for the denial. This in turn generates the notice to the claimant.

The SA also routes a sample of the determinations to the Claims Review Section in the Regional Office and forwards the remaining folders to the district office.

The Disability Regional Office (DIRO) Role in the Reconsideration Process

Title II—Disability Insurance

The DIRO's primary role in the Title II reconsideration process is one of technical and administrative direction of the SA's in coordination with the Central Office; also technical direction to the district offices and coordination of DO and SA activity.

Title XVI—Supplemental Security Income

The DIRO provides administrative, technical and professional direction to the SA's and technical direction to the district offices. Also coordinates SA and DO activity.

They also have responsibility for performing a sample review of the determinations prepared by the SA and DO's. Training and guidance in SSI claims processing is also provided.

Bureau of Disability Insurance (BDI) Role in the Reconsideration Process

Title II—Disability Insurance

The BDI central office is responsible for interpretation of the law and regulations as applied to the reconsideration process. Guides for applying the law in evaluating disability are also provided for the State agency. Central office reviews a 10% sample of SA reconsideration determinations and provides guidance to the SA by returning cases requiring further development or other actions.

Awards and denial notices are also assigned and released by the central office.

Title XVI—Supplemental Security Income

Central office is responsible for providing instructions and guidance for evaluating SSI claims for disability and blind payments, including those special instructions pertaining to the reconsideration process.

2. FACE-TO-FACE INTERVIEW

Summary of State agency reconsideration interview study (SARIS)

Staff question: *We understand some new ideas are about to be tried out in the reconsideration area which may involve face-to-face contact with the claimant. Please describe these developments.*

I. *Introduction*

The State Agency Reconsideration Interview Study (SARIS) was conducted within five State agencies (California, Georgia, Iowa, New York and Texas) from December 1970 to May 1971. It was designed to determine if a personal interview between the claimant and the decision-maker at the State agency reconsideration level would:

(*a*) Result in more complete development of evidence.

(*b*) Reassure the claimant that all of the facts of his case had been considered in the decision.

(*c*) Satisfactorily resolve more cases below the hearing level (as evidenced by reduction in hearing requests).

II. *Study Design*

The test population was restricted to those claims wherein the claimant lived in the same metropolitan area as the State agency, except in Iowa where the study was conducted State-wide and Texas where claimants in certain other metropolitan areas were also included.

All reconsideration cases were initially processed in the normal manner at the district office and State agency. When all necessary development of evidence had been completed in each case, and it appeared that the denial would be affirmed, the cases were examined to screen out those cases in which certain factors would preclude a satisfactory interview (communication barrier, confidential material evidence, etc.).

Cases accepted for the study were randomly separated into a control group and an interview group. Those in the control group had the denial determination finalized in the regular manner and were forwarded to the Division of Reconsideration in Baltimore. In each interview case, the claimant was invited to meet personally with the State agency disability examiner to discuss his case and to bring with him any additional evidence which he considered pertinent to a decision.

In metropolitan areas, the interviews were usually held in State agency facilities but in outlying areas the examiner often traveled extensively to conduct interviews in the claimant's home, an attorney's office, or a district office. During the interview, the examiner was able to review pertinent portions of the case with the claimant, obtain additional information of the claimant's medical condition and vocational factors, and observe any limitations which the claimant might have. If the interview provided leads to additional evidence, this evidence was obtained prior to preparation of the decision. Where no necessity for further development could be established, the disability examiner gave the claimant a full explanation of the reasons for the denial and his future appeal rights.

The procedures for selecting study cases differed in New York and Texas from those in other States. In New York, all reconsideration cases were reviewed by its quality assurance unit which regularly conducts a sample review of all categories of the agency's cases to determine problem areas, trends, and training needs. Only those reconsideration cases in which the quality review detected no apparent development or evaluation problem were included in the SARIS study. Texas reviewed a portion of its cases in a similar manner before selection for the study. No review was conducted by the quality assurance units of the other States. These varying procedures are believed to have had some effect on the percentage of decision change at the reconsideration level.

III. *Study Results*

(*a*) *Decision change at reconsideration.*—

	Interview cases			Control cases		
		Decision changed			Decision changed	
	Total	Number	Percent	Total	Number	Percent
California	103	23	22. 3	99	1	----------
Georgia	91	28	30. 8	65	1	----------
Iowa	33	7	21. 2	25	0	----------
New York	280	39	13. 9	248	4	----------
Texas	184	35	21. 3	147	2	----------
Total	671	[1] 132	19. 6	584	[1] 8	1. 3

[1] These changes were in addition to the usual number of reversals initially made by the SA's after evaluation and review of the evidence during the reconsideration process.

The percentage of decision change in California, Iowa, and Texas were similar. Of the five study States, Georgia had the highest initial denial rate and the lowest reconsideration change rate in its normal case work. The major factor in New York's low change rate in the study is believed to have been the quality assurance screening before sample selection. The eight control case decisions which were changed were the result of review and return to the State agency by the Division of Reconsideration.

One-quarter of the reconsideration decision changes were the result of consultative examinations. Nearly one-half were based on the introduction of new medical evidence submitted by the claimant or obtained from a treating source, and the remainder were the result of additional vocational development or a combination of vocational development and evidence gleaned from the interview.

(*b*) *Hearing requests.*—A major objective of the study was to determine if the interview procedure was effective in reducing the number of hearing requests. The study showed varied results in the individual States, but about the same national rate for hearing requests in both the control and interview groups.

	Interview cases			Control cases		
		Hearing requests			Hearing requests	
	Total	Number	Percent	Total	Number	Percent
California	80	29	36. 2	98	48	49. 0
Georgia	63	33	52. 4	64	29	45. 3
Iowa	26	6	23. 1	25	9	36. 0
New York	241	98	40. 7	244	86	35. 2
Texas	129	48	37. 2	145	69	47. 6
Total	539	214	39. 7	576	241	41. 8

(*c*) *Decision change at the hearing level.*—An 80 percent sampling of the cases which went to a hearing provided the following results:

Interview cases: Total, 163; decision changed, 46, (22.2 percent).
Control cases: Total, 196; decision changed, 73, (37.2 percent).

This experience no doubt reflects the screening out of more allowable interview cases at reconsideration (III.a.).

IV. *Limitations on Validity of Study Results*

(*a*) Each State screened its reconsideration workload to exclude from the study all DWB, CDB, CDI and prior workshop cases. Certain impairments, e.g., contagious diseases, and psychiatric and other mental disorders were also excluded. Some other types of cases excluded: if there was a language barrier, confidential evidence in file, or the claimant did not desire to participate. Because of these exclusions, approximately 45–50 percent of the reconsideration workload in the five pilot States was not considered in the study. Undoubtedly, this introduced a bias into the study results.

(*b*) Further study bias was introduced because the pilot States, except Iowa, restricted the study population only to metropolitan areas in order to minimize travel requirements. Therefore, almost 95 percent of the cases came from metropolitan areas.

(*c*) Only 671 reconsideration claimants were interviewed during the study (six-tenths of one percent of the reconsideration workload). It would appear that this sample is too small in view of the exclusions to provide the confidence in projections necessary for national application. Two-thirds of all the cases in the study came from two States—New York and Texas.

V. *Administrative Issues in Implementing Such a Procedure Nationally*

(*a*) Most optimistically, a State agency examiner might review the file and interview four claimants each day, provided these claimants could be scheduled for their interview at a central location. If travel to several locations were necessary, this figure would be correspondingly lower. Projections as a result of SARIS show that a minimum of 254 additional examiner-years would be necessary for each 100,000 reconsideration interviews to conduct interviews only in the metropolitan areas. Should States conduct the interviews State-wide, this projection might be increased by as much as 50 percent because of travel time and other time-consuming factors.

(*b*) Additional information regarding other costs such as necessary organizational changes and travel costs of State-wide implementation are not available in the study results due to a wide variation of unit costs from State-to-State. Further study is required under expanded testing with stricter controls and reporting to accurately define all costs and facilities required for State-wide implementation on a national basis.

VI. *Procedural Changes and Improvements Subsequent to Study*

(*a*) A factor which biased study results was the introduction of the screening of all reconsideration cases by the quality assurance unit prior to selection for the study. All cases were screened in New York and approximately one-half in Texas. The decision change rate for New York was the lowest of all States (13.9%) and that of Texas was only one-tenth of one percent higher than Iowa, the next lowest State. From this it would appear that a more thorough review of the evidence in file would measurably reduce the reversal rate. Subsequent to the study, QA units in all States have been expanded as has the quality of the supervisory review at all levels. Additionally, the QA units are now formally reviewing a proportionate share of the SA's reconsideration case workload. These actions in all States have assisted in bringing about a reduction in the rate of change of decision on reconsideration since the beginning of 1973.

(*b*) Most States are now using the telephone to contact reconsideration claimants where there is a question unanswered or it appears that additional sources may exist. New York, which tested this study procedure in 1971, reported that the telephone contact provided it with the same amount of information acquired through personal interview. We believe that this selected type of contact where the evidence is inconclusive is more efficient and economical than universal interviews.

VII. *Conclusions*

At the conclusion of the SARIS experiment, BDI, coordinating with the States' Council Committee on Social Security Relationships, decided not to implement the SARIS procedures as carried out in this experiment on a nationwide, mandatory basis. Although the study results were promising in some respects, significant problems and issues (see IV and V above) remained unresolved.

This experiment helped to identify and spotlight several areas where further activity and attention could strengthen the existing reconsideration process as a means of insuring sound and well-documented decisions that could have an effect in reducing the hearing workload. As a result of these studies, experience gained from court decisions, and other special reports, new BDI instructions were issued to provide more comprehensive State agency and district office guidance in the development and evaluation of claims at the reconsideration level. Among the actions stressed have been the expansion of the State agency quality assurance units to enable management to assess the quality of the operation and increased use of personal or telephone contact with the claimant as appropriate to promote improved documentation and decision-making. More intensive sample reviews of SA reconsideration actions by BDI, together with reinforced SA quality assurance activity, are placing stronger focus on the quality of these decisions.

Description of New SSI Regulations on Reconsideration

Staff question: ***In Social Security Regulations No. 16, Subpart N, Section 416.1417, procedures regarding the reconsideration process in Supplemental Security Income disability claims are described. Who is conducting the informal and formal conferences described therein? What is the experience thus far under this process? Provide a detailed explanation of the procedure and its ongoing application.***

Most reconsiderations of initial determinations on applications in disability cases will take the form of a case review, the same process we use for Title II Social Security reconsiderations. The informal conference may be used in cases turning on the question of the claimant's work activity since this issue is now within the jurisdiction of the District Office. For medical issue reconsiderations, Regulation 416.1418(b) allows an informal conference at the discretion of SSA as an alternative to a case review but we believe its use will be rare since it would entail travel by State agency personnel.

Reconsideration of initial determinations of continuing eligibility (post-eligibility claims) in disability cases will be limited to work cessations. If advance notice of the adverse action is required, the reconsideration process for these cases will be a formal conference in the district office. There is no reconsideration process for medical cessation cases which require advance notice of the adverse action. Claimants in these cases will be offered a hearing as their first appellate step. If a case does not require advance notice of the adverse action, the reconsideration process will be either a case review or an informal conference.

As can be seen from the above, informal and formal conferences in disability cases will normally be limited to work activity issues and will be conducted by district office personnel. They will be claims representatives or persons higher than claims representatives in the district office structure.

We have had almost no experience with the formal conference to date because there have been few, if any, work cessations. It is too early for us to be able to describe with any certainty what our experience has been with the informal conference.

3. MANDATORY RECONSIDERATION

Staff question: ***The Harrison Subcommittee had some questions about "mandatory reconsideration" and instructed the Department to "watch the process of mandatory reconsideration very closely and report to the committee on its operation". Was a report ever made to the Committee on this? What studies, internal or external, have touched on this subject apart from those conducted by Mr. Horsky and George Washington University Law group?***

On October 29, 1963, the Department of Health, Education, and Welfare, in response to the Honorable Wilbur D. Mills' letter of July 12, 1963, sent to him its report on developments that had taken place since the Harrison Subcommittee review. The report, pertinent pages of which are attached, pointed out that mandatory reconsideration had proved to be not only useful to the Government but also beneficial to the claimants. Specifically, the report pointed out that 1 out of 3 of the disability cases that go to reconsideration are reversed at that level and that the average time required to complete reconsideration of a case is only about half as long as the elapsed time from the filing of a request for hearing to a decision by the Administrative Law Judge.

Over the years, we have periodically reviewed the mandatory reconsideration policy established in 1959. We have concluded in each instance that the administrative and claimant-service considerations which actuated its adoption were still applicable and that the policy was basically sound.

The States' Council Committee on BOASI Relationships, in the report of their meeting of January 27–28, 1964, found that "On the whole, mandatory reconsideration serves a worthwhile purpose in that it results in allowance of a sizeable percentage of claims in less time and at smaller expense than if hearings had been held."

The report of Professor Robert G. Dixon, Jr., George Washington University Law Center, submitted to the Committee on Grant and Benefit Programs of the Administrative Conference of the United States on October 27, 1971, touches briefly on the reconsideration process although not directly on the mandatory aspects. The report does observe, however, that "By correcting 'erroneous' details at this level, the delay and expense of a hearing examiner proceeding may be avoided."

[Report From the Social Security Administration Regarding the Letter From Congressman Wilbur D. Mills, Chairman, Committee on Ways and Means]

The disability program was first established by the "disability freeze" provisions of the 1954 amendments of the Social Security Act. It was greatly expanded by the cash benefits provisions of 1956, 1958 and 1960. Each of these provisions presented major administrative challenges and to cope with them, the Social Security Administration had to handle massive initial workloads with some amount of improvisation which was not intended to be embodied in ultimate procedures. At the time the Subcommittee held hearings, we were emerging from the initial impact of the first two sets of amendments, and the Subcommittee played an important role in expediting changes in policy and procedures through its observations and recommendations. This report describes administrative accomplishments since the Subcommittee's hearings.

* * * * * * *

Requirement of Reconsideration Before Appeal

The policy under which a claimant is required to go through the reconsideration process before he is eligible for hearing has proved to be not only useful to the Government, but beneficial to claimants. We recognize the need for a slight modification of this policy where it is clear that reconsideration will serve no useful purpose.

The Subcommittee expressed some concern about the requirement that an individual must go through the reconsideration process before he is eligible for hearing. The Subcommittee felt that if this meant a substantial increase in over-all processing time, the requirement should be eliminated.

Mandatory reconsideration was instituted in 1959, shortly before the Subcommittee's hearings. This changed requirement in the appellate process did not affect a large proportion of cases of dissatisfied applicants. Prior to this change, in 80 percent of the hearing cases the claimants had first requested formal reconsideration even though they had a choice of alternatives—reconsideration or hearing.

One of the major factors influencing the Social Security Administration's decision to require reconsideration before hearing is that such a process aids in the prompt identification and expeditious change of decision for those claimants most likely to have a valid case for change. As a matter of fact, approximately 1 out of 3 of the disability cases that go to reconsideration are reversed at that level. The average time elapsing from the date of filing a request for reconsideration to a determination in a disability case is 77 days—only about half as long as the current elapsed time from the filing of a request for hearing to a decision by the hearing examiner. Thus, a considerable number of people are awarded benefits more quickly during reconsideration than if, having been given the alternative, they went directly to hearing.

In the case of disability determinations, almost all reconsideration reversals are based on additional vocational or medical evidence. Not infrequently the new evidence results from an independent consultative examination purchased at Government expense. The new evidence received in connection with the reconsideration action generally reflects any additional medical developments that have occurred between initial adjudication and the time a claim is reconsidered, and hence may provide more specifics with respect to diagnosis, severity and remediability at the time of application. In such cases, reconsideration rather than a hearing is obviously to the claimant's benefit since he receives a decision more promptly.

On the other hand, in cases where the disallowance is affirmed on reconsideration, the claimant receives a more comprehensive explanation of the reasons why under the law and regulations benefits are not payable to him. As a result of the more detailed explanation of the basis for the disallowance, many of these people come to the realization that their cases do not have merit and thus do not request a hearing which involves a more extended type of administrative adjudication. Even in the case of a claimant who wishes to pursue his rights to a hearing the time involved in processing his request for reconsideration will not appreciably delay a final disposition of his case at hearing since the additional evidence developed at the reconsideration level—evidence which the hearing examiner would otherwise be required to obtain—permits the hearing examiner to reach a decision much more quickly. Thus the ultimate effect of mandatory reconsideration is to expedite a final administrative decision, to avoid unnecessary expensive hearings in allowances, and to provide hearing examiners with a more fully developed record in disallowances.

In addition, because the appellate review of disability claims generally involves the examination of new evidence not available at the initial stage of adjudication, we feel that reconsideration before hearing is more in keeping with the spirit of the law since it gives the States an opportunity to evaluate the new evidence. This opportunity would be denied them if the appellate process permitted the individual to go directly to a hearing since adjudications after hearing come under Federal jurisdiction.

Over the years, we have maintained records and analyzed claimants' reactions to the requirement of reconsideration. Except in rare instances, claimants have not expressed dissatisfaction with this procedure. This, of course, is not to infer that there is complete satisfaction with the process or that, aside from any complaint, it is necessary to require reconsideration in *all* cases. We recognize that there are occasional cases where no useful purpose is served by requiring the individual to go through reconsideration. For example, in situations where the claim has been reviewed a number of times by the State in the initial adjudication process, and no further pertinent evidence is submitted or available, the chances of reversal are remote. Reconsideration in such cases might be of no material value. Also, there may be instances in which the claimant, represented by an attorney, challenges an interpretation of law or regulation and wants to expedite his client's "day in court".

As a result of these considerations, we have been giving further thought to the present policy of mandatory reconsideration in the regulations. We believe that at least in these areas, reconsideration need not be required. We have under consideration a set of criteria which would permit the individual to go directly to hearing after the initial adjudication of the case. If, on the basis of further developments and experience, it appears that these criteria should be broadened, then steps will be taken to make the necessary changes.

4. LENGTH OF TIME FOR APPEAL

Staff question: ***It has been suggested that one of the problems with the appeals process is the length of time allowed under the statute in which a claimant may appeal. Do you have any statistical data which indicates when, during the 6-month period, people most commonly appeal? Is the configuration about the same for reconsideration and hearing? If you interpret reconsideration as not the decision in section 205 (b), why do you allow up to 6 months for a request for reconsideration?***

Data on the length of time between applicant receipt of an initial denial notice and filing of a request for reconsideration is not routinely collected and analyzed. Special analyses of the issue, however, have been performed from time to time, the most recent in November 1972. As the table below shows, the filing time configuration is about the same at both the reconsideration and hearing level.

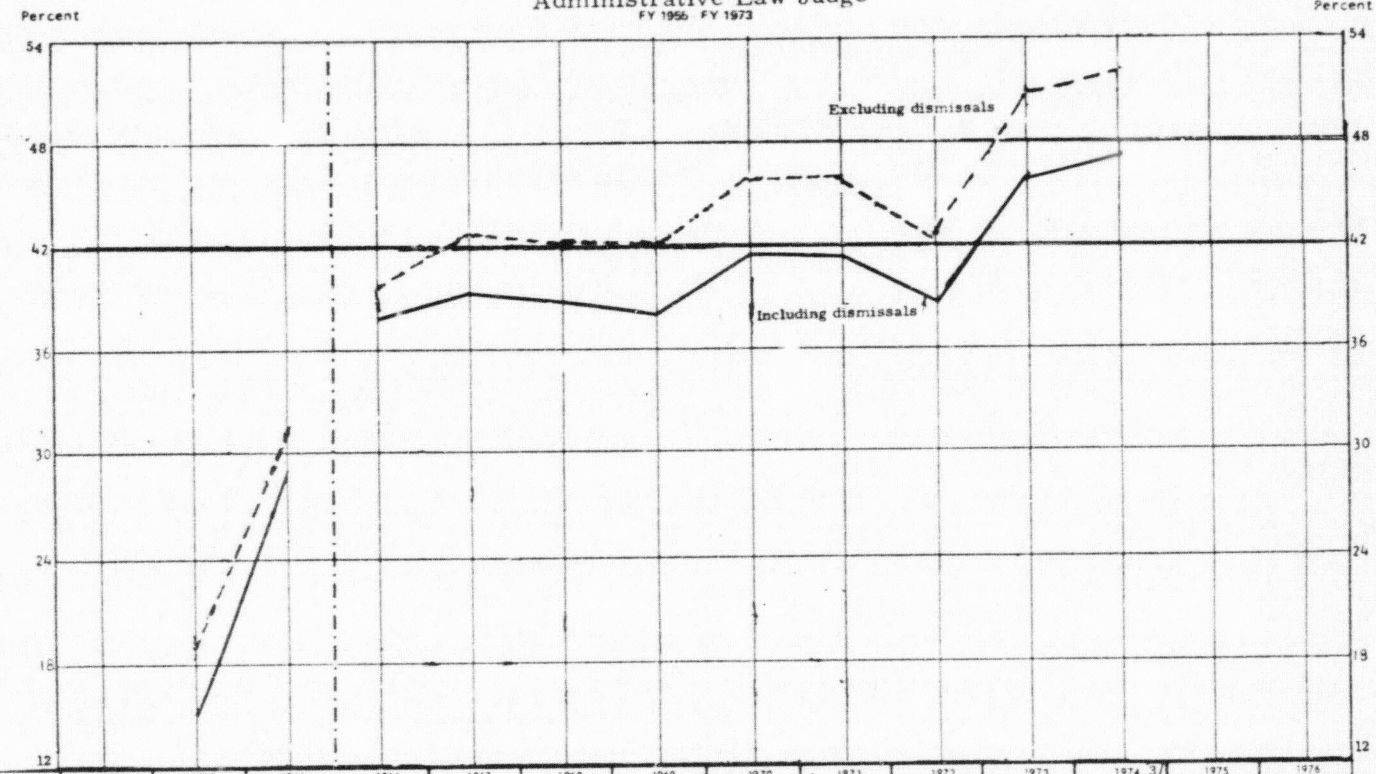
	Reconsideration		Hearing	
Internal	Percent	Cumulative	Percent	Cumulative
Elapsed days from date of denial notice to date of filing of appeal:				
0 to 5	5.9	5.9	4.0	4.0
6 to 10	13.2	19.1	15.4	19.4
11 to 15	9.1	28.2	5.3	24.7
16 to 20	6.5	34.7	9.1	33.8
21 to 25	4.7	39.4	7.0	40.8
26 to 30	5.4	44.8	3.7	44.5
31 to 60	17.0	61.8	16.0	60.5
61 to 90	11.3	73.1	12.4	72.9
91 to 120	8.1	81.2	6.4	79.3
121 and over	18.8	100.0	20.7	100.0
Mean (days)		60.9	----------	65.6
Median (days)		36.0	----------	39.0

Section 205(b) of the Social Security Act prescribes that claimant shall have not less than six months after notice is mailed in which to request hearing. SSA by regulation has interposed mandatory reconsideration as the first appellate step. If the claimant had less than six months in which to exercise his right to reconsideration and, failing to exercise this right, was thereby precluded from exercising his right to hearing, he would in effect be deprived of his right to a full six-month period after notice of SSA's decision in which to request a hearing.

C. HEARINGS AND APPEALS

1. HEARINGS

PERCENT FAVORABLE-TO-CLAIMANT ACTIONS
Administrative Law Judge
FY 1956 FY 1973



CATEGORY	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974 3/	1975	1976
Inc. dis. 1/	NA	15.2%	28.9%	37.7%	39.5%	38.8%	38.2%	41.6%	41.5%	38.6%	46.0%	47.1%		
Exc. dis. 2/	NA	19.3%	31.6%	40.8%	42.8%	42.2%	42.0%	46.3%	46.3%	42.7%	51.5%	52.1%		

SOURCE: Budget Management Section   NA-Not Available

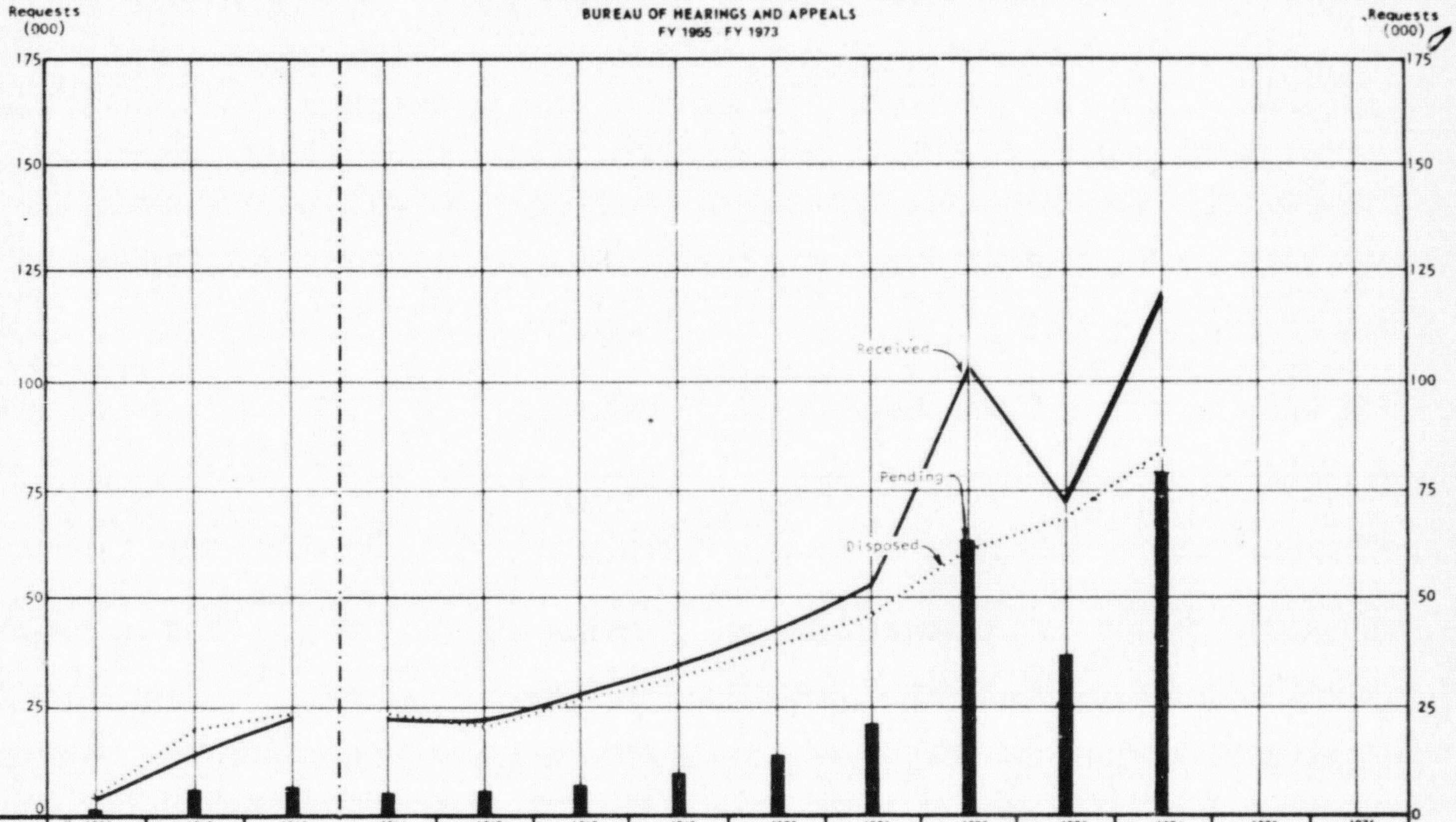
1/ Reversals as a percent of the total cases decided and dismissed.

2/ Reversals as a percent of the total cases decided, but excluding cases dismissed.

3/ 1974 figures exclude 14,781 Black Lung cases and 121 SSI cases.

Hearing Requests Received, Disposed, Pending

BUREAU OF HEARINGS AND APPEALS
FY 1955 - FY 1973



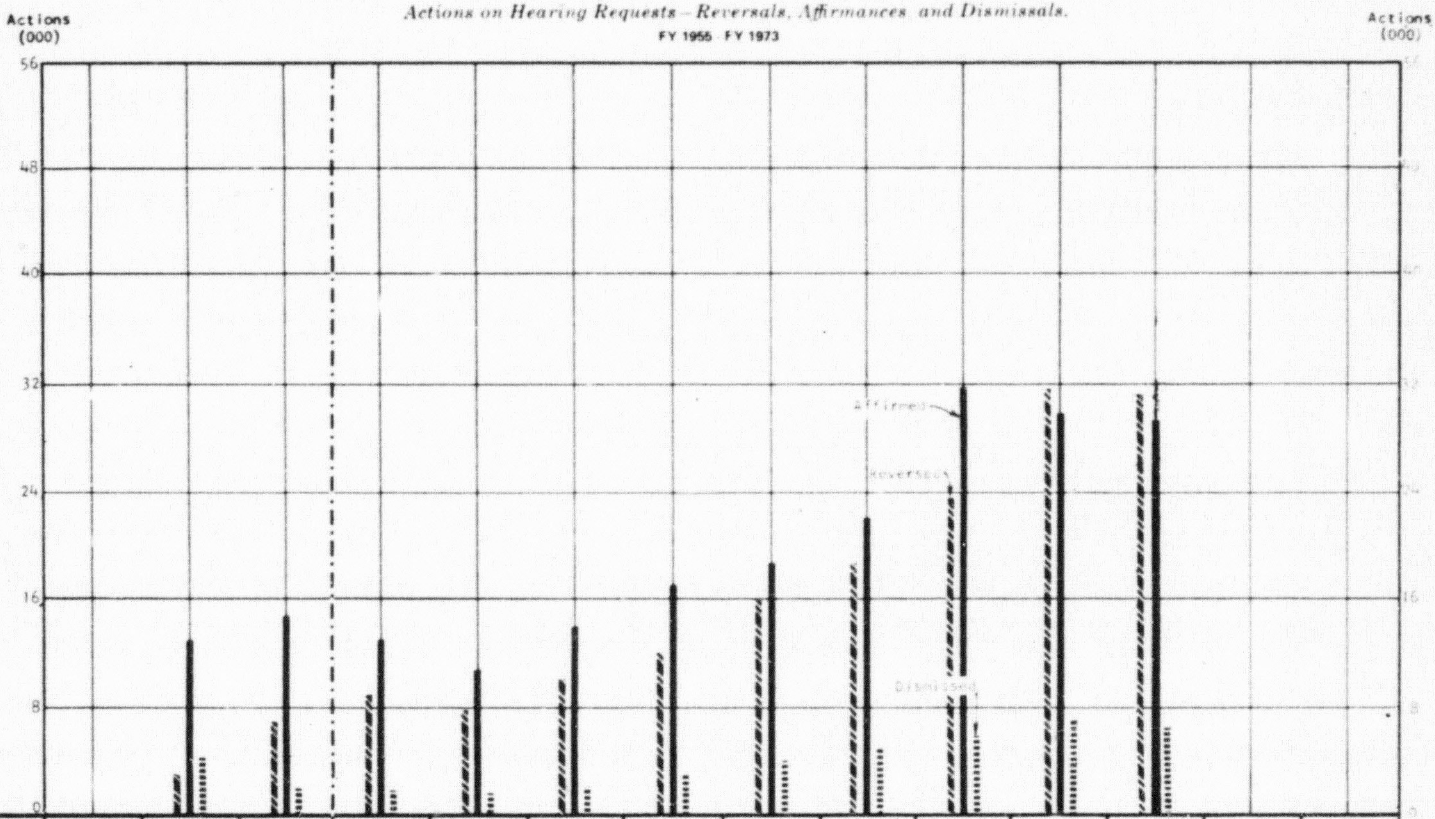
REQUESTS	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
PENDING	1,304	12,443	6,524	6,454	5,654	6,315	7,322	9,654	13,747	20,873	63,534	36,780		
RECEIVED	4,009	13,778	23,323	22,634	20,742	26,946	34,244	42,573	52,427	103,691	72,202	121,500		
WORKLOAD	5,313	26,221	29,847	29,088	26,396	33,261	41,566	52,227	66,174	124,564	135,736	158,280		
DISPOSED	4,131	20,262	23,393	23,434	20,081	25,939	31,912	38,480	45,301	61,030	68,356 1/	81,047		
PENDING	1,182	5,959	6,454	5,654	6,315	7,322	9,654	13,747	20,873	63,534	36,780	77,233		

SOURCE: HA 570

1/ Excludes 30,600 black lung cases remanded to DDI.

Actions on Hearing Requests – Reversals, Affirmances and Dismissals.

FY 1955 - FY 1973

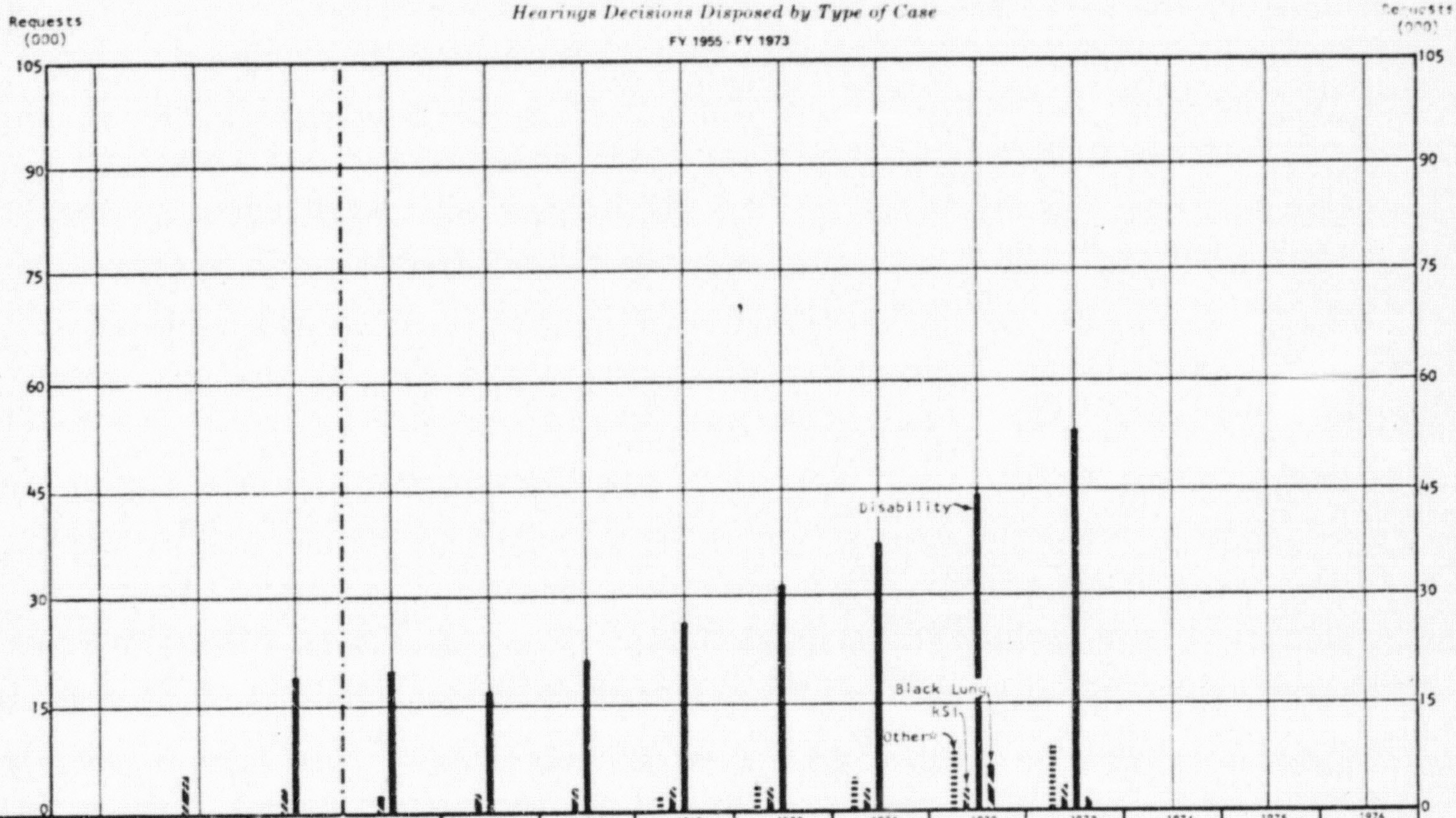


ACTIONS	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974 1/	1975	1976
REVERSED	NA	3,076	6,754	8,838	7,938	10,075	12,206	16,005	18,791	23,573	31,467	31,043		
AFFIRMED	NA	12,788	14,578	12,804	10,581	13,769	16,789	18,542	21,759	31,574	29,623	28,456		
DISMISSED	NA	4,398	2,061	1,792	1,562	2,095	2,917	3,933	4,751	5,883	7,266	6,378		
TOTAL	NA	20,262	23,393	23,434	20,081	25,939	31,912	38,480	45,301	61,030	68,356	65,877		

SOURCE: HA 570 NA - Not Available NOTE: Data for "Total" are not plotted. 1/ Figures for 1974 do not include 14,781 Black Lung cases and 121 SSI cases.

Hearings Decisions Disposed by Type of Case

FY 1955 - FY 1973



REQ DISP'D	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
OTHER*	--	--	--	0	43	337	2,151	3,969	4,893	8,045	8,905			
RSI	NA	5,288	3,292	2,526	2,720	3,237	3,210	3,000	2,867	2,704	3,196			
DISABILITY	NA	14,974	20,101	20,908	17,318	22,275	26,551	31,511	37,541	44,048	53,368			
BLACK LUNG	--	--	--	--	--	--	--	--	--	6,233	2,887			
TOTAL	4,131	20,262	23,393	23,434	20,081	25,939	31,912	38,480	45,301	61,030	68,356			

SOURCE: HA 570

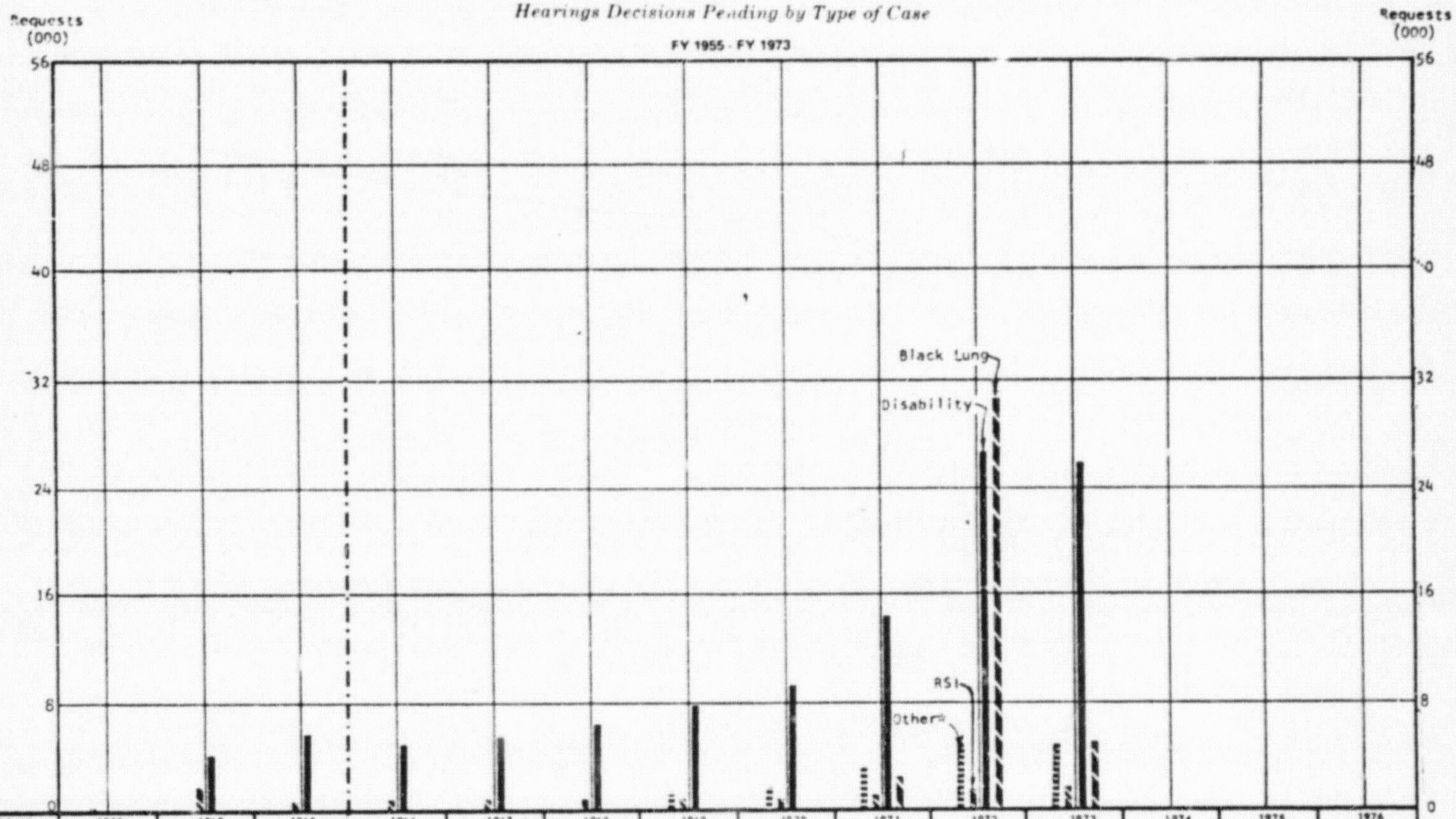
NA-Not Available

NOTE: Data for "Total" are not plotted.

*Includes HIB-SMIB (1966) and DWIB (1969) programs

Hearings Decisions Pending by Type of Case

FY 1955 - FY 1973



REQ PENDING	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
OTHER*	--	--	--	2	70	129	988	1,577	3,119	4,852	4,660			
RSI	NA	1,627	729	734	833	822	864	988	1,075	1,529	1,684			
DISABILITY	NA	4,332	5,725	4,918	5,412	6,371	7,792	11,182	14,353	26,651	25,597			
BLACK LUNG	--	--	--	--	--	--	--	--	2,326	30,502	4,839			
TOTAL	1,182	5,959	6,454	5,654	6,315	7,322	9,654	13,747	20,873	63,534	36,780			

SOURCE: HA 570 NA-Not Available NOTE: Data for "Total" are not plotted.

*Includes HIB-SMIB (1966) and DWIB (1969) programs

Staff question: ***We understand that for SSI cases, there will be a procedure for remand from the Hearing Examiner back to the State agency. What will be the criteria for use of this action? How much do you anticipate it will be used?***

Section 416.1435 of the SSI regulations provides "Where new and material evidence is received or there is a change in law, regulations, or other precedents which would permit findings favorable to the individual, the presiding officer, in his discretion, may remand the case to the appropriate Administration office for a revised determination where such action would expedite payment to the individual."

The "appropriate Administration office" could include a State agency in the event new and material evidence were received which clearly pointed to an allowance. The difficulty is that disability evidence is usually not that clear; therefore, we believe that this process will not be very often used in instances where the issue is the individual's disability. Also, if clear evidence of a disability allowance were received, a quickly prepared hearing decision would result in quicker payment than a remand to the State agency would (because the State agency would have to review *de novo*).

Of course, if there were a change in the law or regulations or if a court decision changed the interpretation of the law or regulations, this remand procedure might be used with respect to the class of individuals affected by the change.

2. APPEALS COUNCIL

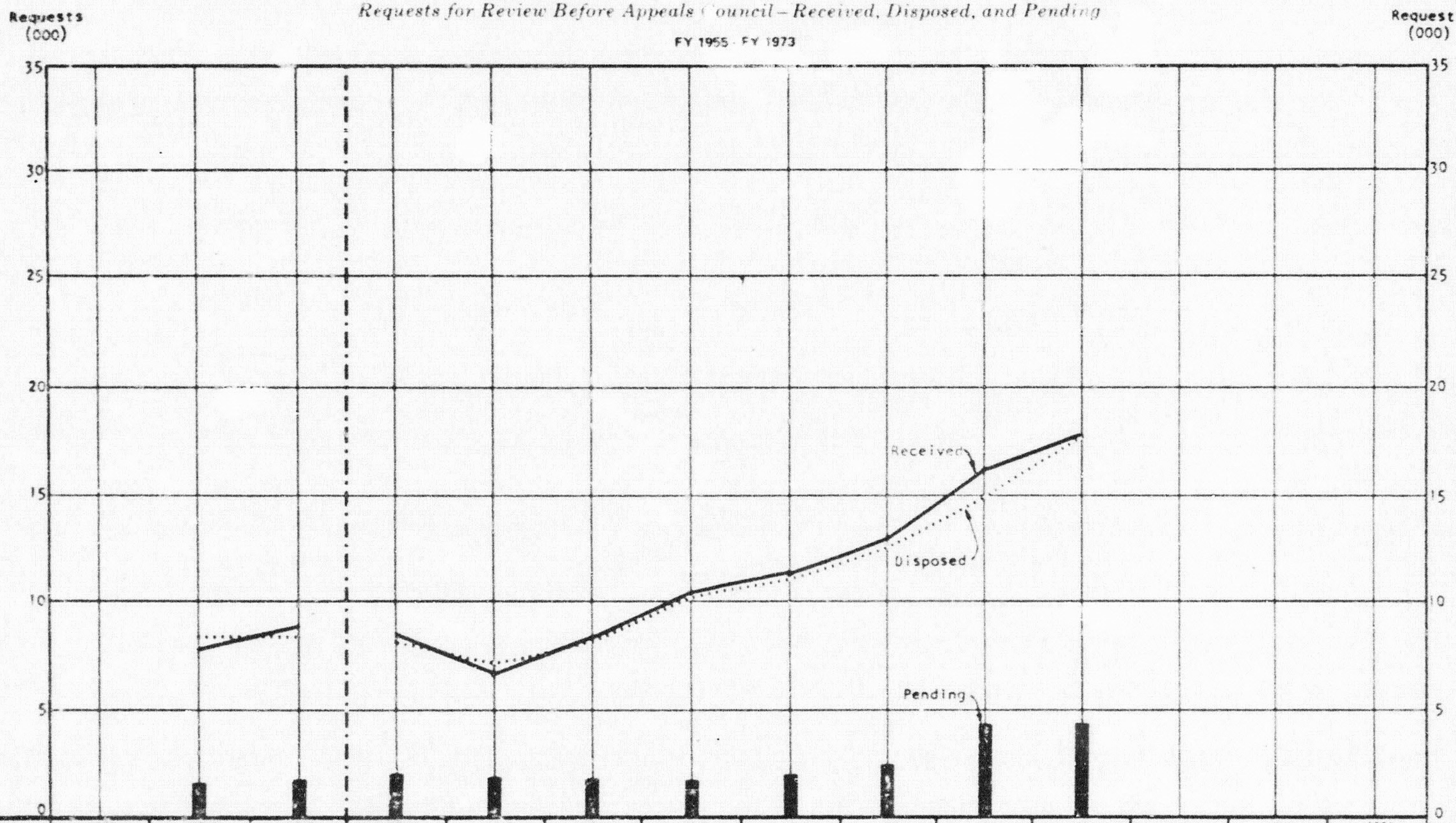
Staff question: ***In how many cases in fiscal 197[illegible] did the Appeals Council, on its own motion, review decisions of the ALJ's? How does this compare with the experience in 1960?***

Following are charts which show the breakout by program of own motion recommendations and decisions processed. The own motion decision figure is the number of decisions written by the Appeals Council during that period of time.

Fiscal year	Disability insurance beneficiary	Disabled widows insurance beneficiary	Retirement and survivors insurance	Health insurance	Black lung	Total
Staff recommendations for own motion review by Appeals Council:						
1961	74		121			195
1962	66		43			109
1963	85		56			141
1964	138		120			258
1965	165		115			280
1966	122		138			260
1967	208		142	19		369
1968	280		93	24		397
1969	346	26	134	76		582
1970	456	104	102	200		862
1971	466	49	130	306		951
1972	473	42	143	302	179	1,139
1973	693	81	133	291	85	1,283
Own motion decisions processed by Appeals Council:						
1961	62		96			158
1962	65		64			129
1963	52		23			75
1964	129		110			239
1965	132		120			252
1966	134		98			232
1967	157		90	[illegible]		251
1968	191		88	29		308
1969	192	14	90	33		329
1970	335	84	93	108		620
1971	375	61	85	176		697
1972	326	24	100	251	14	715
1973	514	32	118	158	11	833

Requests for Review Before Appeals Council – Received, Disposed, and Pending

FY 1955 - FY 1973



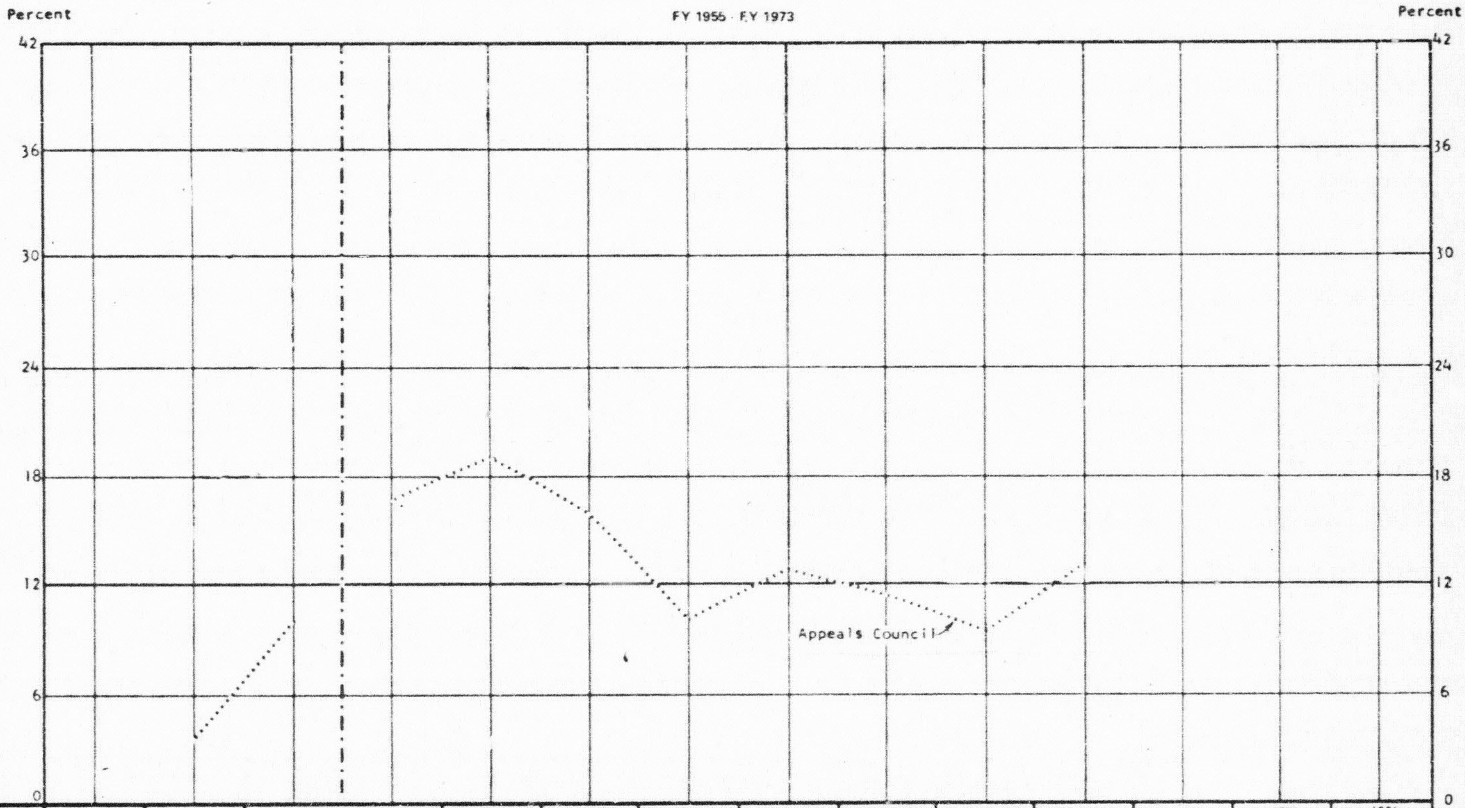
REQ FOR REV	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
PENDING	NA	2,444	1,290	1,755	1,947	1,659	1,802	1,736	1,911	2,434	4,373			
RECEIVED	NA	7,408	8,785	8,243	6,719	8,286	10,038	11,259	13,104	16,780	17,789			
WORKLOAD	NA	9,852	10,075	9,998	8,726	9,945	11,840	13,005	15,015	19,214	22,162			
DISPOSED	NA	8,386	8,320	8,051	7,067	8,143	10,104	11,094	12,581	14,841	17,773			
PENDING	NA	1,466	1,755	1,947	1,659	1,802	1,736	1,911	2,434	4,373	4,381 1/			

SOURCE: HA 572 NA - Not Available

1/ Excludes 8 cases transferred to the Black Lung Center.

Appeals Council – Percent Favorable-to-Claimant Actions

FY 1955 - FY 1973



CATEGORY	1955	1960	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
APP COUNCIL	NA	3.6%	9.6%	15.9%	17.8%	11.1%	9.9%	12.4%	11.1%	9.2%	12.3%			

SOURCE: Budget Management Section NA-Not Available

D. Development and Use of Precedent Material

1. REGULATIONS AND DISABILITY STATE MANUAL

Staff question: ***What substantive changes have been made in the Disability Insurance State Manual and the Federal Regulations since the 1967 Amendments?***

A. *Regulations*

Changes in the Regulations relating to disability and the definition of disability from 1967 to present, follow.

1. Provisions relating to comparable work activity performed by statutorily blind individuals age 55 or over were clarified and made part of the regulations (20 CFR 404.1503).

2. Regulation 404.1507 relating to failure to follow prescribed treatment was added. At the same time the previous concept of remediability was removed from the regulations. This was in keeping with expression by the Senate Finance Committee, as discussed on page 99 (copy attached) of their Report on the 1965 amendments, that an individual who willfully fails to follow prescribed treatment which is expected to restore his ability to engage in substantial gainful activity could not by virtue of such failure qualify for benefits.

3. The regulations were updated to reflect a Commissioner's Decision of 7/11/66 to raise the SGA earnings criterion from $100.00 to $125.00 a month and to cover related changes pertaining to the evaluation of earnings from work (20 CFR 404.1534). Based on a subsequent Commissioner's decision dated 12/12/68, the regulations were again updated to raise the SGA earnings criterion from $125.00 to $140.00 and to make corresponding changes relating to the evaluation of work activity (20 CFR 404.1534).

4. Regulations relating to the evaluation of disability in the case of widow-(er)s were added to implement section 223(d)(2)(B) by providing that unless his or her physical or mental impairment or impairments meet the duration requirement of the law and also are of a level of severity which meet or equal the level of the listing of impairments, such individual may not be determined to be under a disability (20 CFR 404.1504).

5. A new section (20 CFR 404.1501(c)) was added to comply with the 1967 change in the Social Security Act, defining a physical or mental impairment as ". . . an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." This conforms with the intent of Congress that "statements of the applicant or conclusions by others with respect to the nature or extent of impairment or disability do not . . .", by themselves, establish the existence of disability for purposes of social security disability benefits and must be supported by clinical or laboratory findings, or other medically acceptable evidence (page 30 of the report of the House Ways and Means Committee on H.R. 12080—the 1967 Amendments—copy attached).

6. The concept of medical equivalence was defined by the addition of a new regulation (20 CFR 404.1505) providing that an individual's impairment or impairments shall be the equivalent of an impairment listed in the appendix only if the medical findings with respect thereto are at least equivalent in severity and duration to the listed impairments.

7. The "National Economy Test" for determining the availability of work to an individual with a physical or mental impairment was added to the Regulations (20 CFR 404.1502(b)). This complies with the intent of Congress "to provide a definition of disability which can be applied with uniformity and consistency throughout the Nation, without regard to where a particular individual may reside, to local hiring practices or employer preferences, or to the state of the local or national economy" and helps prohibit use by the courts of a variety of concepts which greatly weaken our position in the courts (pages 28–30 of the Report of the House Ways and Means Committee and pages 46 thru 50 of the Senate Finance Committee on H.R. 12080—the 1967 Amendments—copies attached).

8. The Listing of Impairments was incorporated into the Regulations and appropriate changes made to other affected sections of the Regulations (20 CFR 404, Subpart P Appendix).

B. Disability Insurance State Manual

Changes in the Disability Insurance State Manual relating to disability and the definition of disability from 1967 to present, follow:

1. The Social Security Administration's Disability Insurance Letter (DIL) No. III–8 dated January 8, 1968 and a Supplement dated May 10, 1968 provided policies and procedures implementing changes in the law made by the 1967 amendments. These instructions included guidelines concerning: a) The national economy test, b) widow(er)'s disability c) substantial gainful activity, d) definition of impairment nd e) medical equivalency:

2. The Social Security Administration's Disability Insurance Letter (DIL) No. II–38, issued on 12/14/72 following enactment of the 1972 Amendments, described the disability and related provisions of the amendments and furnished interim guides for evaluating and processing of cases affected by these Amendments. These Instructions included guidelines concerning: a) changes under which entitlement to childhood disability benefits could be based on disability since before age 22, instead of before age 18, b) reentitlement to childhood disability benefits, c) changes that liberalized the insured status requirement for statutorily blind workers to require fully insured status but not special insured status, d) the reduction in the waiting period from six to five months.

2. SOCIAL SECURITY RULINGS

Staff question: ***Describe the genesis of a "Social Security Ruling". Where does it come from, who puts it together, who reviews it? Give some illustrations that come from General Counsel opinions, Hearing Examiner decision, Appeals Council. How many ruling are cited by Administrative Law Judges?***

As "publisher" of the Social Security Rulings, the Regulations and Rulings Branch, Division of Technical Services (the DTS), Bureau of Retirement and Survivors Insurance, is the focal point for control of the publication of appropriate source materials which may serve as the bases for rulings. Policy staffs of all components are responsible, however, for making available to DTS appropriate source materials. Rulings may be based upon such source materials as initial and reconsidered determinations, policy memoranda, Administrative Law Judge or Appeals Council decisions, Commissioner's Rulings, Office of General Counsel Opinions and Federal Court decisions.

Upon recommendation from the substantive component, or on its own volition, DTS drafts a ruling in a prescribed format which is appropriate to the nature of the source material. The substantive component, if it wishes, may prepare an initial draft and submit it to DTS which then reviews the draft, in essence for conformity to standards of style and format and consistency with applicable sections of the law, regulations and policies.

Those rulings drafted by DTS are reviewed by the substantive component and are then returned to DTS. After its evaluation and incorporation of comments received from the substantive component, DTS prepares a clearance draft which is sent to the Office of General Counsel (OGC) and the Bureau of Hearings and Appeals (BHA) for comments and/or approval. DTS evaluates those comments received from OGC and BHA and attempts to reconcile any differences between the substantive components, OGC and BHA. A final draft is then prepared by DTS and sent to OGC and BHA for final signature; informational copies are released to all interested components. After OGC and BHA have cleared the final draft, DTS prepares the final draft for printing and arranges for publication.

Only those rulings which reflect either an Appeals Council decision, court decision, or a Commissioner's decision indicate the source in the ruling. SSR 73–26c (July 1973) presents an opinion of a United States Court of Appeals. The source material for SSR 73–27 (July 1973) was an Office of General Counsel Opinion. SSR 73–31 (July 1973) was based on the decision of an Administrative Law Judge, and a Commissioner's Decision formed the basis for SSR 73–54 (November 1973).

We have no statistics as to the number of rulings cited byAdministrative Law Judges.

Staff question: ***For the social security rulings you have published this fiscal year, who recommended them, i.e., the "substantive component"?***

The Social Security Rulings published or to be published in fiscal year 74 (7/73—5/74) were recommended by the following components as shown:

July 1973 issue:	
SSR 73-25	Division of Technical Services
SSR 73-26c	Do.
SSR 73-28	Do.
SSR 73-29	Do.
SSR 73-30	Do.
SSR 73-31	Do.
SSR 73-32	Do.
SSR 73-33c	Do.
SSR 73-34c	Bureau of Health Insurance and Bureau of Hearings Appeals
SSR 73-35a	Bureau of Health Insurance
SSR 73-36	Bureau of Disability Insurance
SSR 73-37	Do.
SSR 73-38	Do.
September 1973 issue:	
SSR 73-39c	Division of Technical Services
SSR 73-40	Do.
SSR 73-41	Division of Entitlement, BRSI
SSR 73-42	Division of Technical Services
SSR 73-43	Do.
SSR 73-44c	Division of Technical Services
SSR 73-45c	Do.
SSR 73-46c	Do.
SSR 73-47c	Do.
SSR 73-48	Do.
SSR 73-49a	Bureau of Hearings and Appeals
SSR 73-50a	Division of Technical Services
SSR 73-51c	Do.
November 1973 issue:	
SSR 73-52c	Division of Technical Services
SSR 73-53c	Do.
SSR 73-54	Division of Coverage, BRSI
SSR 73-55	Do.
SSR 73-56	Do.
SSR 73-57	Division of Technical Services
SSR 73-58c	Do.
SSR 73-59c	Do.
SSR 73-60c	Do.
January 1974 issue:	
SSR 74-1a	Division of Technical Services
SSR 74-2c	Do.
SSR 74-3a	Do.
SSR 74-4	Do.
SSR 74-5	Division of Coverage
SSR 74-6c	Division of Technical Services
March 1974 issue:	
SSR 74-7c	Bureau of Disability Insurance
SSR 74-8c	Division of Technical Services
SSR 74-9c	Do.
May 1974 issue:	
SSR 74-10	Division of Technical Services
SSR 74-11c	Do.
SSR 74-12c	Do.
SSR 74-13	Do.
SSR 74-14c	Bureau of Disability Insurance
SSR 74-15c	Bureau of Hearings and Appeals

3. COMMISSIONER'S DECISION

Staff question: ***What is a Commissioner's Decision? What precedent value does it have? Give an illustration which is relative to the Title II DIB program.***

A commissioner's Decision is a formal decision of the Commissioner that is recorded and printed as a "Commissioner's Decision." Ordinarily these decisions stem from memorandums or submittals to the Commissioner concerning program or administrative issues and policy questions significant enough to warrant his consideration. The SSA component, or components where the issue involved extends across more than one area of responsibility, may submit the issue or question to the Commissioner. Publication of these decisions provides a method of informing interested staff of significant policy changes and major operating decisions. For example, the Commissioner's approval of proposed changes to the regulations is evidenced by his Decision stating he approved the recommended changes and forwarded them on to the Secretary. In addition, a Commissioner's Decision may form the basis for, and be published as, a Social Security Ruling.

It is of precedent value because it is the Commissioner's decision pertaining to policy questions, program matters, and administrative issues, and is binding on all SSA components until rescinded or superseded. A Commissioner's Decision of course, cannot conflict with the law, or the Regulations or with directives from the Secretary.

Attached is an example of a Commissioner's Decision (Tab 1). This decision, dated August 24, 1973, approved for publication —in the Federal Register proposed amendments to Subpart D of Regulations No. 4 reflecting section 116 of Public Law 92–603 which lowered the waiting period requirement in disability cases from 6 to 5 months.

Another example of a Commissioner's Decision is also attached (Tab 2). In a Decision dated September 9, 1972 the Commissioner authorized the release of copies of all medical records in the file of a disability recipient to the recipient's attorney pursuant to an order of the U.S. District Court, Eastern District, Virginia.

Tab No. 1

Commissioner's Decisions of August 24, 1973

* * * * * * *

7. As recommended in a memorandum from the Bureau of Retirement and Survivors Insurance dated August 15, 1973, "Regulations No. 4, Subpart D; Reduction of Disability Waiting Period Requirement to 5 Months," (Document No. 5995.92), the Acting Commissioner:

A. Approved for publication in the Federal Register the Notice of Proposed Rule Making and proposed amendments to Subpart D of Regulations No. 4 reflecting section 116 of Public Law 92–603 which lowers the waiting period requirement in disability cases from 6 to 5 months. The waiting period is that period an individual must serve to receive benefits under title II of the Act on the basis of his disability and/or to establish a period of disability; and

B. Forwarded the Notice and proposed amendments to the Secretary with the recommendation that he approve and release them to the Office of the Federal Register.

Component's reason for recommendation

To reflect changes effected by section 116 of Public Law 92–603, lowering the waiting period requirement from 6 to 5 months.

* * * * * * *

Tab No. 2

Department of Health, Education, and Welfare, Social Security Administration—Commissioner's Decision, September 9, 1972

Concurring in the recommendation contained in a memorandum from the Bureau of Disability Insurance dated September 9, 1972, "Chester A. Spain, SSN 405–12–5638; Disclosure of Medical Information Pursuant to Court Order," (Document No. 3772.77–c), the Commissioner authorized, under his ad hoc authority, the release of copies of all medical records in the file of Chester A. Spain, to Mr. William J. Hudson, attorney for Mr. Spain, for use as evidence in the case of Spain v. Boise Cascade Building Company, as required by order of the U.S. District Court, Eastern District, Virginia. Dr. A. R. Coppola, a consultative physician, has been authorized to testify (if called upon to do so) in connection with the examination he performed on Mr. Spain. Dr. Coppola has consented to the release of the report.

Component's reason for recommendation

To provide medical evidence necessary in a court case.

Present: Mr. Ball, Mr. Hess.

4. RESOLUTION OF DISAGREEMENTS

Staff question: ***What happens when the Bureau of Disability Insurance disagrees with an Appeals Council's interpretation of the Law? Who settles the dispute? Who is bound by the decision and how is the resolved policy communicated to the constituent agencies?***

Since the inception of the disability insurance program, the Bureau of Disability Insurance and the Appeals Council of the Bureau of Hearings and Appeals have not had any differences of opinion in the interpretation of the law which were not resolved through negotiation by representatives of the respective Bureaus. The two Bureaus have always been able to reach a mutual understanding.

If the Bureau of Disability Insurance and the Bureau of Hearings and Appeals should ever have a difference of opinion in the interpretation of the law which cannot be resolved through negotiation by the respective Bureaus and consultation with the Office of the General Counsel, the dispute would be submitted to the Commissioner of Social Security for his decision. The decision of the Commissioner would be binding on all components of the Social Security Administration. All formal Decisions of the Commissioner are recorded as "Commissioner's Decisions," thus providing a method to inform interested staff about Social Security Administration policy and major operating decisions. Copies of the Commissioner's Decisions are distributed to all Social Security Administration components and interested Department of Health, Education, and Welfare staff.

5. ADMINISTRATIVE NOTICE

Staff question: ***Please describe the practice of Administrative Law Judges taking "administrative notice" of the existence of light or sedentary jobs in the national economy.***

Under Section 7(d) of the Administrative Procedure Act an agency may take official notice of facts at any stage in a proceeding providing that such facts be specified and any interested party given the opportunity to show to the contrary.

Although there are Appeals Council decisions which discuss this subject, such decisions are not circulated to the ALJ's as was the practice a number of years ago. Accordingly, unless the decision of the Appeals Council is the subject of a Social Security Ruling, it does not provide any guidance to the ALJ's.

There is a Social Security Ruling, SSR 64–65c, CB 1964, p. 135 based on a court case which is pertinent to this subject (*McDaniel* v. *Celebrezze*, 331 F. 2d 426 (4th 1964)). The syllabus of the ruling reads as follows:

> Where Secretary, in addition to testimony and documentary evidence presented at hearing, considered pertinent recognized publications in this case certain medical texts and industrial and governmental studies of the requirements and availability of various jobs; and where plaintiff had been given an opportunity to challenge and contradict such materials: held, the Secretary's taking official notice of such publications in reaching a decision was proper.

The Court in its decision stated that "Sections 205(a) and (b) of the Social Security Act implicitly authorize consideration of this type of evidence. The procedure followed by the Appeals Council conforms with 57(d) of the Administrative Procedure Act." The court then concluded "that taking official notice of recognized publications is not, in itself, grounds for reversing the decision of the Secretary when the requirements of § 7(d) of the Administrative Procedure Act have been met." The court emphasized that reviewing courts must carefully evaluate this type of evidence in determining whether there is substantial evidence in the record taken as a whole to support the decision of the Secretary.

Taking administrative notice of the incidence of jobs in the economy is clearly permissible under the Administrative Procedure Act and the aforementioned Social Security Ruling. However, the Secretary must first respond to the issue of what type of work this claimant can do. This requires the use of live testimony by a vocational expert.

As recently as March 1974, in the case of *Milagros Santiago Hernandez* v. *Weinberger* (U.S. Court of Appeals, First Circuit, No. 73–1342, 3/15/74), the Court held that the Secretary's burden to come forward with a showing of claimant's capacity to do other work that is available is not satisfied by the Secretary's taking administrative notice of the general availability of light and sedentary work in the national economy.

While the vocational expert is present at the hearing to respond to the issue of what type of work the claimant can [illegible] and is expected to also respond to the issue concerning the inciden[illegible]obs in the economy. This is the preferred approach, since:

(1) it obviates the necessity for the Administrative Law Judge to assume vocational expertise and become involved in the concept of taking administrative notice of jobs in the economy when a vocational expert is already at the hearing.

(2) It may be prejudicial to the claimant's interests to take administrative notice of a broad spectrum of jobs that have not been tailored to his individual circumstances (including prior work experience, age, and education) which would be provided by the vocational expert.

(3) When the vocational expert has provided examples of specific jobs the claimant can do with a minimum of orientation and training based on his residual functional capacity and prior work experience together with the incidence of those jobs, this information, in itself, may open entirely new vistas and provide direction for the claimant. This concept is lacking when administrative notice is taken.

(4) The courts (and the Department of Justice) are conditioned to reviewing cases containing this type of testimony from a vocational expert. They have approved this technique because of its fairness and the availability of the vocational expert for cross-examination. Although the opportunity to object to and refute the noticed facts is provided under § 7(d) of the APA, it is difficult to cross-examine a document or publication.

This procedure is set forth in BHA Handbook Sections 1–87 through 1–87–22 which provide guidance on vocational matters. Certain of these sections (specifically 1–87 through 1–87–10D) have been revised recently.

E. Court Cases and Problems of Litigation

1. COURT CASES

Staff question to Bureau of Disability Insurance: ***What effect have the 1967 amendments had on the administration of the law? How has disability case law developed since the 1967 amendments? What are the main problem areas? How many district and circuit court disability opinions has the Government appealed? List cases and explain method of reaching decision whether to appeal. What are the roles of HEW and Justice in this process? Show court trends in disability from 1967 to present. In how many cases has HEW requested that an appeal be taken from the circuit court to the Supreme Court, but was turned down by the Department of Justice?***

I. *What effect have the 1967 Amendments had on the administration of the law?*

Essentially, the 1967 Amendments, although increasing the overall work load by the addition of two new classes of beneficiaries (disabled widow(er)s and workers disabled while young), did serve to tighten up materially the disability determination process, as intended by Congress by providing more definitive criteria for adjudication of the issue of disability. The changes in the law have been generally accepted by the courts; previously, court decisions tended to provide liberal interpretations of the disability criteria contained in the Social Security Act.

II. *Court trends and disability case law since enactment of the 1967 Amendments*

Overall the courts, which had until the 1967 Amendments been moving towards a liberal interpretation of the law's requirements for disability entitlement, have now generally accepted the provisions of the new amendments which clarified Congressional intentions in the evaluation of the issue of disability.

1. Work availability test.—Although some courts continued for a time following the 1967 Amendments to speak in terms of local job availability or employer's hiring practices there was, by and large, rapid judicial acceptance of the work availability test laid down by the Amendments. Most courts now seem to agree, in line with the change made in § 223(d) by the 1967 amendments, that where the plaintiff's impairment makes him unable to do his previous work, the issue is, rather, whether he is able to engage in any substantial gainful work which exists in significant numbers in the national economy, either in the region where the individual lives or in several regions of the country, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

2. Substantial gainful activity.—Although the substantial gainful activity concept was introduced into the regulations in 1961, the 1967 amendments provided for the first time specific statutory authority to prescribe the criteria for determining whether work performed by an impaired individual demonstrates ability to engage in substantial gainful activity. This helped overcome judicial resistance to the substantial gainful activity concept and resulted in it being generally accepted by the courts. Faced with evidence of such work or earnings most courts have affirmed the Secretary's finding.

3. Medical documentation provision.—There has been little judicial discussion of the medical documentation provision of the 1967 Amendments and the overall impact of the medical documentation provision on judicial thinking remains obscure. While no real problem is presented, some courts continue to place great weight on subjective complaints and make independent evaluations of the evidence not in keeping with the "substantial evidence" rule. Judicial interpretation of "medically acceptable clinical and laboratory diagnostic techniques" has generally been less demanding than the Administration's interpretation.

4. Trend of court decisions.—Of the 3,434 district court decisions rendered on the merits during the period July 1955 through December 1967 the Secretary's decision was affirmed in 66 percent of the cases whereas for the period January 1968 through December 1973, during which 4,886 such court decisions were handed down, the Secretary's decision was affirmed in 81 percent of the cases. The continuing upward trend in the rate of affirmances by the courts is substantiated by the more recent decisions. The affirmance rate went from 81 percent for 1971 to 84 percent for 1972 and to all time high of 85 percent for 1973.

During same period of time, July 1955 through December 1967, there were 1,242 remand allowances and, based on court affirmances, court reversals and Appeals Council allowances after court remand, the combined affirmance rate was 48 percent. From 1968 through 1973 there was a total of 1,507 remand allowances and the combined affirmance rate was 62 percent.

III. *What are the main problem areas?*

Overall there have been no major problem areas; however, there has been some questionable interpretation of the ". . . medically acceptable clinical and laboratory diagnostic techniques" that are required by the law and Regulations to demonstrate the existence of a physical or mental impairment, with some courts continuing to accept mere conclusions or subjective allegations as to disability that are unsupported by any objective significant findings.

There has also been the occasional tendency of some courts to interpret "work which exists in the national economy"—added by the 1967 Amendments—to mean work for which the claimant would be hired—a definition which is much more favoarble to the claimant.

IV. *How many district and circuit court disability opinions has the Government appealed?*

Since the inception of the disability program from July 1955 through December 1973 there have been 102 appeals of district court disability decision by the Government. During the 12 year period July 1955 through December 1967 we appealed 56 (4.77%) out of 1174 district court reversals whereas during the 6 year period January 1968 through December 1973 we appealed 46 (5.04%) out of 912 district court reversals. In addition, there have been 3 decisions by Courts of Appeals in which the government requested and was granted certiorari since the inception of the program. These cases are identified as *Richardson* v. *Perales*, 402 U.S. 389 (1971) (upheld the admissibility of written medical reports as evidence and the use of medical advisors by Administrative Law Judges), *Richardson* v. *Bolchor*, 404 U.S. 78 (1971) (upheld the constitutionality of the Workmen's Compensation offset provisions (section 224 of the Social Security Act), and *Richardson* v. *Wright*, 405 U.S. 208 (1972), *reh. den.* 405 U.S. 1033 (1972) (remand by the Supreme Court to reprocess under new Social Security Administration guides for furnishing advance notice of disability cessation before benefits are stopped).

V. *Explain method of appeal and the roles of HEW and Justice in this process*

All district court disability reversals are carefully reviewed for appeals consideration. Generally speaking, appeals of these cases are not taken on an individual basis. The fact that the court had readjudicated the case on the evidence of record is usually not a basis for a recommendation to seek appellate review, even where the court seems to have disregarded the substantial evidence rule. Appeal is recommended in cases where serious program implications and a strong factual record coexist. The emphasis on a record without factual weakness is to avoid, insofar as possible, an adverse decision by an appellate court which would be much more harmful to the program as a precedent.

Comments and recommendations relating to appeals of adverse district court decisions in disability cases are prepared by (1) the Bureau of Hearings and Appeals, (2) the Bureau of Disability Insurance and (3) In many cases the DHEW Regional Attorneys located in the region of the district court.

These recommendations as to appeal are forwarded to the Office of the General Counsel. The Office of the General Counsel may agree with a recommendation not to appeal or may concur that an appeal is warranted, or may decide against the recommendation. In any event the case is forwarded with the Office of the General Counsel's recommendation, either for or against appeal to the Appellate Section (Civil) of the Department of Justice. Justice Department action on a possible appeal is resolved by the Office of the Solicitor General, which makes the final decision whether to pursue a Government appeal of a Social Security court decision. The appearance in court and actual trial of a case appealed by the Government is handled by the Justice Department.

VI. *List of cases wherein appeal was sought by DHEW*

The following is a list of district court disability decisions which were appealed by the Government subsequent to the 1967 Amendments. This list of cases, with citations and outcome, was supplied by BHA. The blank spaces result from the information not being readily available.

SSN	Name	Circuit	C/A decision date	Citation
113-22-8388	Doyle, J. W	5th	Apr. 19, 1972	Rem. Ct. 458 F. 2nd 987
183-20-6006	Lloyd, M. E	D.C	Pending	
235-09-4323	Rowe	4th	June 11, 1970	Aff. Dept. 427 F. 2nd 417
235-70-6100	Estep, K. L	4th	Apr. 25, 1972	Aff. Dept. 459 F. 2nd 1015
242-66-6833	Wilson, F. L	4th	Feb. 14, 1972	Rem. Ct. 455 F. 2nd 304
246-14-3758	Leviner, O. C	4th	June 8, 1971	Aff. Dept. 444 F. 2nd 1338
249-03-8741	Harris, A. R		Pending	
249-05-5003	Peoples, R. H	4th	May 11, 1972	Rem. Ct. 455 F. 2nd 924
249-26-9855	Huckabee, C. E	4th	Nov. 17, 1972	Rem. Ct. 468 F. 2nd 1380
250-54-6352	Blalock, R. R	4th		Aff. Dept.-Cit. not avail.
254-14-2148	Oliver, R. D	4th	Oct. 11, 1972	Aff. Dept.-Cit. not avail.
267-05-7530	Harris, M	5th		Rem.-Cit. not avail.
307-01-0433		7th	Oct. 16, 1969	Rev. Dept.-Cit. not avail.
321-09-5428	Cox, D. E	9th	Apr. 12, 1973	Rev. Dept.-Cit. not avail.
327-07-1321		7th		Cit. not avail.
406-22-9248	Carpenter	6th		Aff. Dept.-Cit. not avail.
419-22-9298	Kirkland, W. C	5th	Aug. 15, 1972	Aff. Dept. 480 F. 2nd 46
420-10-2727	Peoples, J. L	5th		Aff. Dept. 468 F. 2nd 601
428-98-7518	Grant, J. W	6th	July 18. 1973	Aff. Dept. 482 F. 2nd 1290
429-18-2523	Sutton, H. M			
448-12-7698	Hedge, R. O	10th		Aff. Dept. 458 F. 2nd 1065
455-12-2851	Brown	5th	July 2, 1970	Aff. Dept. 429 F. 2nd 80
500-07-5988	Tatum, F. W	9th	Apr. 12, 1973	Aff. Dept.-Cit. not avail.
516-32-6481	Torske, C. A	9th	Aug. 31, 1973	Aff. Dept. 484 F. 2nd 59
516-34-5095	Sorenson, C. O	9th	Mar. 14, 1972	Cit. not avail.
554-40-7992	Triller, G. R	9th		Aff. Dept. Cit. not avail.
575-10-8581	Reyes, S	D.C	Feb. 23, 1973	Aff. Dept. 476 F. 2nd 910
576-44-7183	Salinas, L. D	9th	Mar. 14, 1973	Cit. not avail.
577-09-3824	Holliday, G. F	D.C		Rem.-Cit. not avail.
039-07-9510	Pasquale	1st	Dec. 2, 1969	Aff. not timely
202-26-5279	Shelton, A	3rd	June 4, 1970	Aff. Dept. 428 F. 2nd 81
229-32-6311	Ratcliff, A	4th	Feb. 23, 1969	Rev. Dept. 408 F. 2nd 8
233-07-5251	Harrah, L. D	4th	July 2, 1971	Aff. Dept. 446 F. 2nd 1
234-14-0729	Easley, J	4th	Oct. 8, 1970	Aff. Dept. 431 F. 2nd 1351
234-36-1524	Walton, M	4th	Mar. 3, 1972	Aff. Dept.-Cit. not avail.
248-54-1610	Whiten, P. B	4th	Feb. 3, 1971	Aff. Dept. 437 F. 2nd 73
249-05-5003	Peoples, R. H	4th	May 11, 1972	Rem. Ct. 455 F. 2nd 924
250-05-5535	Sargent, R. C	4th	June 15, 1971	Aff. Dept.-Cit. not avail.
250-14-8813	Berry, J. H	4th	Nov. 3, 1971	Still pending
254-14-2148	Oliver, R. D	4th		Aff. Dept.-Cit. not avail.
254-48-7139	Bedford, E	5th	Mar. 14, 1973	Aff. Dept. 473 F 2nd 1386
277-05-0658	Clifford, H. K	6th	May 19, 1971	Rem. Dept.-Cit. not avail.
296-16-5509	Otworth, H	6th	Dec. 10, 1970	Rev. Dept. 435 F 2nd 542
350-03-9553	Atteberry, W. A	10th	Apr. 15, 1970	Rev. Dept. 424 F. 2nd 36
400-36-4848	Pilcher	6th		Rem.-Cit. not avail.
467-16-4475	Woods	5th	Dec. 30, 1970	Aff. Dept.-Cit. not avail.
568-09-3691	Grant, J. C	5th	June 29, 1971	Aff. Dept. 445 F. 2nd 656
582-01-8700	Gonzaleza	1st	Mar. 2, 1972	Aff. Dept. 455 F. 2nd 953
289-01-5966	Hughes	ED. KY	May 21, 1971	Aff. Dept.-Cit. not avail.
198-26-3281	Esposito	ED. PA	1971	Aff. Dept.-Cit. not avail.
181-14-2557	Gentile	3rd	Feb. 3, 1970	Aff. Dept. 423 F. 2nd 244
580-64-2807	Robles-Reyes	1st	Mar. 5, 1969	Aff. Dept. 409 F. 2nd 84
	Brandon	4th	July 25, 1972	Aff. Dept.-Cit. not avail.
265-24-2441	Gold, E	5th	Feb. 16, 1973	Aff. Dept. 473 F. 2nd 1376
405-18-7165	Meadows, P	5th	Feb. 4, 1969	Aff. Dept. 409 F. 2nd 750

VII. *In how many cases has DHEW requested that an appeal be taken from the Circuit Court to the Supreme Court but was turned down by Justice?*

In six cases involving disability (listed below) the Department of Justice has turned down DHEW's request that an appeal be taken from the Circuit Court of Appeals to the Supreme Court.

Charles Teeter—7th Circuit, 1959
Dollie Kohrs—8th Circuit, 1959
Philip Kerner—2nd Circuit, 1960
Carl Massey—6th Circuit, 1965
Wm. Hodgson—3rd Circuit, 1966
John Leftwich—4th Circuit, 1967

Staff question to the Bureau of Hearings and Appeals: *What has been the court experience in disability cases and what are your major problem areas?*

Our court experience has generally been satisfactory. Since 1970, the affirmation rate has been 80 percent or higher. Nevertheless, there are some areas of concern.

In the Sixth Circuit, the Court of Appeals' decision in *Giddings* v. *Richardson*, 480 F2d. 653 (1973), has created some problems with respect to the evaluation of medical evidence. The Court, in that decision, brought into sharper focus a criterion favored by many courts; namely, that greater weight should be accorded the reports, findings and conclusions of treating physicians than those of consulting physicians. This was accomplished through a rationale holding that where the treating physician renders an opinion that a disability claimant is unable to work (a not uncommon opinion), such opinion cannot be rebutted by the reports of consulting physicians which are "silent" on the issue of whether the claimant's impairments do, in fact, prevent him from working. Stated another way, the court refused to accept interpretations by the administrative law judge of medical reports and conclusions, and required that the consulting physicians themselves translate their own medical findings into residual functional capacity to perform vocationally significant functions.

Another area of concern is the Eighth Circuit. In *Garrett* v. *Richardson*, 471 F2d. 598 (1972) the Court of Appeals for the first time required the Secretary to produce live vocational testimony to establish whether or not an individual was capable of engaging in substantial gainful activity. The decision is ambiguous as to its meaning, but we have interpreted it as standing at least for the proposition that the Secretary has the burden of producing vocational testimony whenever the evidence establishes that the claimant cannot perform his previous work. However, it is possible that the court intended that the Secretary have the burden of producing vocational testimony whenever the claimant denies that he can do his usual work. Subsequent decisions by the court in *Johnson* v. *Richardson*, 486 F2d. 1023 (1973), and *Willem* v. *Richardson*, CCH $17,715 (1974), appear to give some substance to this interpretation.

Insofar as the district courts are concerned, the major problems appear to lie in the Sixth Circuit. A comparison of figures for 1972 and 1973 is revealing. These courts were responsible for less than 18 percent of the total reversals in 1972, and for over 42 percent in 1973. While there were a number of reasons for this increase, a review of the decisions issued by these courts reveals that the single most important reason was the *Giddings* decision (*supra*). The district courts have not only literally followed the rationale in that decision, but have expanded on it in some instances, stating that a consultant physician must render an opinion on whether or not the claimant is able to work, even when the physician reports normal or negative findings with regard to every body system.

The district courts in the Sixth Circuit have traditionally been troublesome in terms of reversing the Secretary, and *Giddings* has given them whatever leverage they have needed to insist upon an adjudicative approach which the Secretary has in the past felt unnecessary, time-consuming, expensive and contrary to the policy that findings on the ultimate issue was for the trier of the facts and not the medical profession. In 1973, the national reversal rate was 17 percent; six of the nine district courts in the Sixth Circuit had reversal rates in excess of that figure, ranging from 22 percent in the Middle District of Tennessee, to 55 percent in the Southern District of Ohio. In addition, although its reversal rate was only about 11 percent, the Eastern District of Kentucky Court was responsible for almost 12 percent of the total number of reversals nationally.

As indicated by the above statistics, the Southern District of Ohio Court presents the most serious problem, not only because of its extremely high reversal rate, but because it is a high-volume court. The following points should be noted as the reasons for our difficulties in this jurisdiction: (1) Relying heavily on *Giddings* (*supra*), the court has ignored or rejected reports from consulting physicians and has accorded almost controlling weight to the opinions and reports of treating physicians. This has been especially true where the consulting physicians expressed no opinion on the claimant's ability or inability to work. (2) The court has, in several instances in the past year, reversed on the "relating back" theory, i.e., where the evidence has demonstrated a severe impairment subsequent to the expiration of the claimant's insured status, the mere fact that some degree of impairment existed while the claimant was insured has been sufficient for the court to "relate back" the current severity to the period in which the claimant was still insured. In many instances, the court has related the present severe impairment to a period many years in the past, choosing to ignore evidence which rebutted a finding of severity during the period of insured status. (3) The court has a tendency to accept subjective complaints as disabling, even in the absence of any physical findings to explain them. The court cites a 1967 decision, *Branham* v. *Gardner*, 383 F2d. 614, to allow such cases, since *Branham* requires a favorable decision where subjective complaints are caused by emotional factors. This court requires acceptance of complaints unless the claimant is a malingerer, et cetera. (4) Vocational expert testimony is rejected because, in the view of the court, the hypotheticals do not include considerations of pain and other subjective symptoms, or do not otherwise fully reflect the true medical picture.

The record of the Western District of Michigan Court is accounted for by the fact that one of the two judges has, in the past 12 years or so, affirmed the Secretary in only two cases, in both of which the claimants were engaging in substantial gainful activity. He has stated in explicit language that his "social philosophy" with respect to the adjudication of disability claims is diametrically opposite that of the Social Security Administration. The other judge in this jurisdiction affirms the Secretary in virtually every case.

Garrett (*supra*) has had some effect on how district courts in the Eighth Circuit view our cases. Thus, because of the ambiguities in that decision, district courts have remanded cases to have a vocational expert testify because the claimant established that he had a medical impairment (regardless of whether it rendered him incapable of engaging in his former work) or to have a vocational expert testify to resolve conflicts in the *medical* evidence. If, in fact, the *Garrett* decision does stand for this proposition, we could be facing a significant administrative problem.

We are also having some problems in three district courts outside of those in the Sixth and Eighth Circuits. The first of these, South Carolina, has always been troublesome. This court continues to give almost controlling weight to opinion evidence from treating physicians, while categorically rejecting medical advisor testimony. Ironically, it relies upon the *minority* opinion in *Perales* to do so. In 1973, this court had a reversal rate of 30 percent, and its reversals accounted for over 11 percent of the national total.

The Western District of Virginia Court had a 44 percent reversal rate, with its reversals accounting for six percent of the national total. Here, again, the adverse trend is due to the decisions of only one of the judges in this jurisdiction, and the reversing decisions issued by this judge reflect a personal dislike and mistrust of vocational experts. It is the belief of this judge that the use of hypothetical medical questions or assumptions to elicit testimony from vocational experts smacks of prejudgment on the part of the administrative law judge, and is therefore unfair to claimants.

As in Virginia and Michigan, the adverse situation in the Oregon Court is due solely to the anti-Department bias of only one of the four judges in that jurisdiction. This judge has not only rejected, categorically, vocational expert testimony, but has ignored the clear mandate expressed in the 1967 Amendments and has reversed on the basis of local employment conditions, employer hiring practices, et cetera. In September and October 1973, two of his decisions were reversed by the Ninth Circuit Court of Appeals on the ground that he was applying a legal standard which had been obsoleted by the 1967 Amendments. Decisions issued by this judge late in 1973 reflect his acceptance of the mandate of Congress and the Circuit Court, and the picture in this jurisdiction should change.

One final court which has created difficulties for the Department in the past year is the Puerto Rico District Court. Its reversal rate is only five percent, but it has used the remand procedure to express disagreement with the Department on several basic issues. Many of the remands appear frivolous and suggest that the Court is embarked on "fishing expeditions." The Court concedes that there is substantial evidence to support the Secretary's decisions, but "in the interest of justice," or some equally vague basis, remands for further development. In many cases it will remand for current medical examinations although the claimant's insured status had expired many years before the application was filed. Its decisions also reflect disagreement with our evaluation of subjective complaints and psychiatric impairments. Most important, however, is its view regarding nonmedical factors. This court has taken the position that it will not sustain the Secretary merely because a claimant can perform the duties of jobs existing in the national economy, but requires us to prove that impaired claimants can work with the same degree of efficiency or productivity as individuals with lesser or no impairments.

In calendar year 1973, the Office of the General Counsel processed 201 court reversals, most of which were disability cases. It recommended appeal to the Department of Justice in 23 disability cases.

Staff question to Bureau of Hearings and Appeals: ***What is the criteria used for requesting court review of adverse decisions?***

The following answer is from section 7-100 Bureau of Hearings and Appeals Handbook.

7-100-10 *Criteria for appeal*

The criteria to be used in determining whether an appeal should be recommended in a case where a court has reversed a final decision of the Secretary differ from those involved in determining whether or not a new court case should be defended on the record. The primary concern in the court's reversal is the seriousness of the administrative implications. The fact that a court has disregarded the substantial evidence rule and readjudicated the case is usually not a sufficient basis, in itself, for a recommendation to seek appellate review.

Generally, a court's reversal will be considered as having serious administrative implications if the decision is contrary to the Social Security Act, the regulations, or the practices of the Social Security Administration and might have a precedent effect on future cases in other jurisdictions. The following are examples of adverse judicial decisions having serious administrative implications:

(1) The court's decision negates congressional intent; e.g., the court applies an occupational disability test.

(2) The court's decision, if followed, would adversely affect the social security program or the hearing process; e.g., the court holds that the use of a medical advisor is improper.

(3) The court holds that a regulation is invalid; e.g., the court holds that the conclusion of a treating physician as to the severity of a claimant's impairments is determinative of the question of whether or not the individual is disabled.

(4) The decision of the court disregards or violates a major proposition of law; e.g., the decision holds that the Secretary may not take official notice of information not in the record, (5 USCA 556(e), formerly section 7 of the Administrative Procedure Act).

The above examples are not all-inclusive. The analyst must exercise his independent judgment in determining whether there are serious administrative implications in a reversal.

In certain circumstances, the Branch may recommend to the AC that a reargument be sought. For example, this recommendation may be made if the court establishes an onset date and orders payment from the date of onset without regard to the six-month waiting period. An alternative recommendation of appeal (in the event reargument is not granted) should also be made.

7-100 *Court reversals—general*

The Secretary may seek an appeal from adverse decisions issued by district courts and courts of appeal. In certain circumstances, reargument may be sought.

When a court has reversed a final decision of the Secretary, OGC forwards a written memorandum to the Bureau requesting that the Bureau forward its comments by a specified date with respect to the administrative implications of the court's decision and its views as to appeal. The decision as to whether or not appeal is recommended is made by a majority vote of the AC. In the event of a tie, the vote is considered to be against appeal.

Since there is a time limitation for taking an appeal or seeking reargument, court reversal cases should be handled expeditiously, and OGC should be notified of the AC's vote as soon as possible

2. STATISTICS ON DISABILITY AND BLACK LUNG CASES

The following tables were prepared by the Bureau of Disability Insurance. They differ somewhat from other court case statistics prepared by the Office of General Counsel, the Bureau of Hearings and Appeals, and the Administrative Office of the U.S. Courts which also appear in this document. Each of these agencies use their own reporting system and procedures.

TABLE 48.—*District court actions, excluding remands—disability and black lung through December 1973, decisions on merits—cases pending—new actions*

	Decisions					New Actions October–December 1973
	October–December 1973		Cumulative through December 1973			
	Affirmed	Reversed	Affirmed	Reversed	Pending	
1st Circuit:						
Maine	1	0	17	2	0	0
Massachusetts	0	0	51	5	39	5
New Hampshire	0	0	10	4	1	1
Puerto Rico	8	1	208	11	306	42
Rhode Island	0	0	2	1	5	1
Total	9	1	288	23	351	49
2d Circuit:						
Connecticut	0	0	15	1	17	2
New York	2	0	136	12	160	22
Vermont	0	0	3	1	5	0
Total	2	0	154	14	182	24
3d Circuit:						
Delaware	0	0	4	5	13	5
New Jersey	5	1	49	8	54	6
Pennsylvania [1]	8	1	209	99	164	45
Total	13	2	262	112	231	56
4th Circuit:						
Maryland	2	1	48	11	25	5
North Carolina	5	0	121	51	55	5
South Carolina	5	3	311	408	245	37
Virginia [1]	5	4	211	100	108	23
West Virginia [1]	6	0	470	223	89	17
Total	23	8	1,161	793	522	87

See footnote at end of table.

TABLE 48.—*District court actions, excluding remands—disability and black lung through December 1973, decisions on merits—cases pending—new actions*—Con.

	Decisions					
	October–December 1973		Cumulative through December 1973			
	Affirmed	Reversed	Affirmed	Reversed	Pending	New Actions October–December 1973
5th Circuit:						
Alabama [1]	9	0	497	141	76	17
Canal Zone	0	0	0	0	0	0
Florida	4	0	128	15	39	7
Georgia	7	0	210	30	61	13
Louisiana	8	0	278	55	107	18
Mississippi	0	0	134	30	47	8
Texas [1]	8	0	325	72	215	33
Total	36	0	1, 572	343	545	96
6th Circuit:						
Kentucky [1]	61	3	705	205	276	38
Michigan [1]	4	6	132	68	131	30
Ohio [1]	7	12	281	111	162	25
Tennessee [1]	20	3	296	73	76	14
Total	92	24	1, 414	457	645	107
7th Circuit:						
Illinois [1]	2	0	111	23	36	9
Indiana	0	0	95	17	38	10
Wisconsin	1	0	30	6	22	6
Total	3	0	236	46	96	25
8th Circuit:						
Arkansas	7	0	141	30	47	10
Iowa	0	0	14	2	7	2
Minnesota	0	0	34	8	28	2
Missouri	3	1	78	29	39	2
Nebraska	0	0	12	7	8	0
North Dakota	0	0	6	2	2	1
South Dakota	0	0	5	1	3	1
Total	10	1	290	79	134	18
9th Circuit:						
Alaska	0	0	2	0	0	0
Arizona	2	0	57	17	38	3
California	13	1	288	47	166	31
Hawaii	0	0	2	1	4	1
Idaho	1	0	25	2	10	0
Montana	1	1	36	9	8	0
Nevada	0	0	10	0	3	1
Oregon	6	1	74	49	17	5
Washington	5	0	91	15	49	7
Total	28	3	585	140	295	48
10th Circuit:						
Colorado	1	0	25	7	10	1
Kansas	1	0	65	14	21	4
New Mexico	0	1	27	14	5	1
Oklahoma	2	0	117	35	30	5
Utah [1]	0	0	4	3	5	2
Wyoming	0	0	1	0	2	0
Total	4	1	239	73	73	13
District of Columbia	1	0	33	6	45	10
Grand total	221	40	6, 234	2, 086	3, 119	533

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[1] In addition, there were 187 black lung court filings: 63 in Kentucky, 59 in Pennsylvania, 41 in West Virginia, 7 in Alabama, 9 in Virginia, 2 in Ohio, 2 in Tennessee, and 1 each in Michigan, Texas, Utah, and Illinois.

TABLE 49.—*Disability cases—district court actions, filings, and dispositions—by type—through December 1973*

Period	Actions filed	Court decisions			Appeals council remand allowance	Combined affirmance rate (percent)[2]	Other dispositions[3]	Total dispositions	Pending end of period
		Affirmance	Reversal	Affirmance rate (percent)[1]					
July 1955–December 1967	6, 161	2, 260	1, 174	66	1, 242	48	501	5, 177	984
1968	1, 029	360	110	77	174	56	62	706	1, 307
1969	1, 379	508	145	78	192	60	93	938	1, 748
1970	1, 362	592	163	78	203	62	151	1, 109	2, 001
1971	1, 525	688	157	81	297	60	133	1, 275	2, 251
1972	1, 769	794	152	84	257	66	141	1, 344	2, 676
1973	2, 226	1, 032	185	85	384	64	182	1, 783	3, 119
Total	[4] 15, 451	6, 234	2, 086	75	2, 749	56	1, 263	12, 332	
PAST 4 QUARTERS									
1973:									
March	[5] 517	[5] 194	[5] 43	82	[5] 74	62	33	[5] 344	[5] 2, 849
June	[5] 551	304	45	87	[5] 106	67	61	[5] 516	[5] 2, 884
September	[5] 625	[5] 313	57	85	81	69	45	[5] 496	[5] 3, 013
December	533	221	40	85	123	58	43	427	3, 119
Total	2, 226	1, 032	185	85	384	64	182	1, 783	

[1] This affirmance rate does not include appeals council allowances after court remand.

[2] This combined rate is based on court affirmances, court reversals, and appeals council allowances after court remand.

[3] Dismissals in DHEW's favor for untimely filing, failure to exhaust administrative remedies, incorrect designation of party, etc.

[4] In addition, there were 187 black lung court filings. There have been 164 black lung court decisions, all remands.

[5] Adjusted to physical inventory.

TABLE 50.—*Court of Appeals and Supreme Court actions—disability cases dispositions through December 1973—by circuits*

I. COURT OF APPEALS—DISPOSITIONS TO DATE—CASES PENDING

Circuits	Total appeals	Decisions		Other decisions		Total dispensed	Awaiting Court of Appeals action
		For DHEW	Against DHEW	Remands	Technical dismissal [1]		
1	26	14	1	2	4	21	5
2	27	10	2	3	3	18	9
3	47	20	5	9	4	38	9
4	179	94	33	23	20	170	9
5	182	106	11	28	18	163	19
6	188	93	33	32	13	171	17
7	31	19	3	2	5	29	2
8	29	11	6	4	6	27	2
9	82	42	2	4	20	68	14
10	24	11	3	4	2	20	4
District court	6	3	1	1	0	5	1
Total	[2] 821	[3] 423	[4] 100	112	95	730	[5] 91

II. COURT OF APPEALS DECISIONS IN OCTOBER–DECEMBER 1973

Circuit	For DHEW—12 Name and State	Date	District court action
1	Jacques, I. (New Hampshire)	November 1973	Affirmed
4	Forstner, J. (Virginia)	September 1973	Do.
5	Dudley, L. (Louisiana)	August 1973	Do.
5	Hemphill, J. (Florida)	September 1973	Do.
5	Sutton, J. (Georgia)	November 1973	Do.
6	Combs, C. (Kentucky)	October 1973	Do.
6	Randolph, G. (Tennesee)	November 1973	Do.
6	Futernick, N. (Michigan)	June 1973	Do.
9	Bergfelder, H. (California)	October 1973	Do.
9	Ernest, L. (Washington)	July 1973	Do.
9	Torske, C. (Oregon)	August 1973	Reversed.
9	Triller, G. (Oregon)	September 1973	Do.
	Dismissals—2:		
4	Church, E. (West Virginia)	October 1973	Affirmed
5	Weber, J. (Los Angeles)	do	Do.
	Remands—2:		
6	Glover, P. (Kentucky)	do	Do.
8	Johnson, C. (Minnesota)	November 1973	Do.

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[1] Court of Appeals dismissed these 95 appeals for technical reasons.

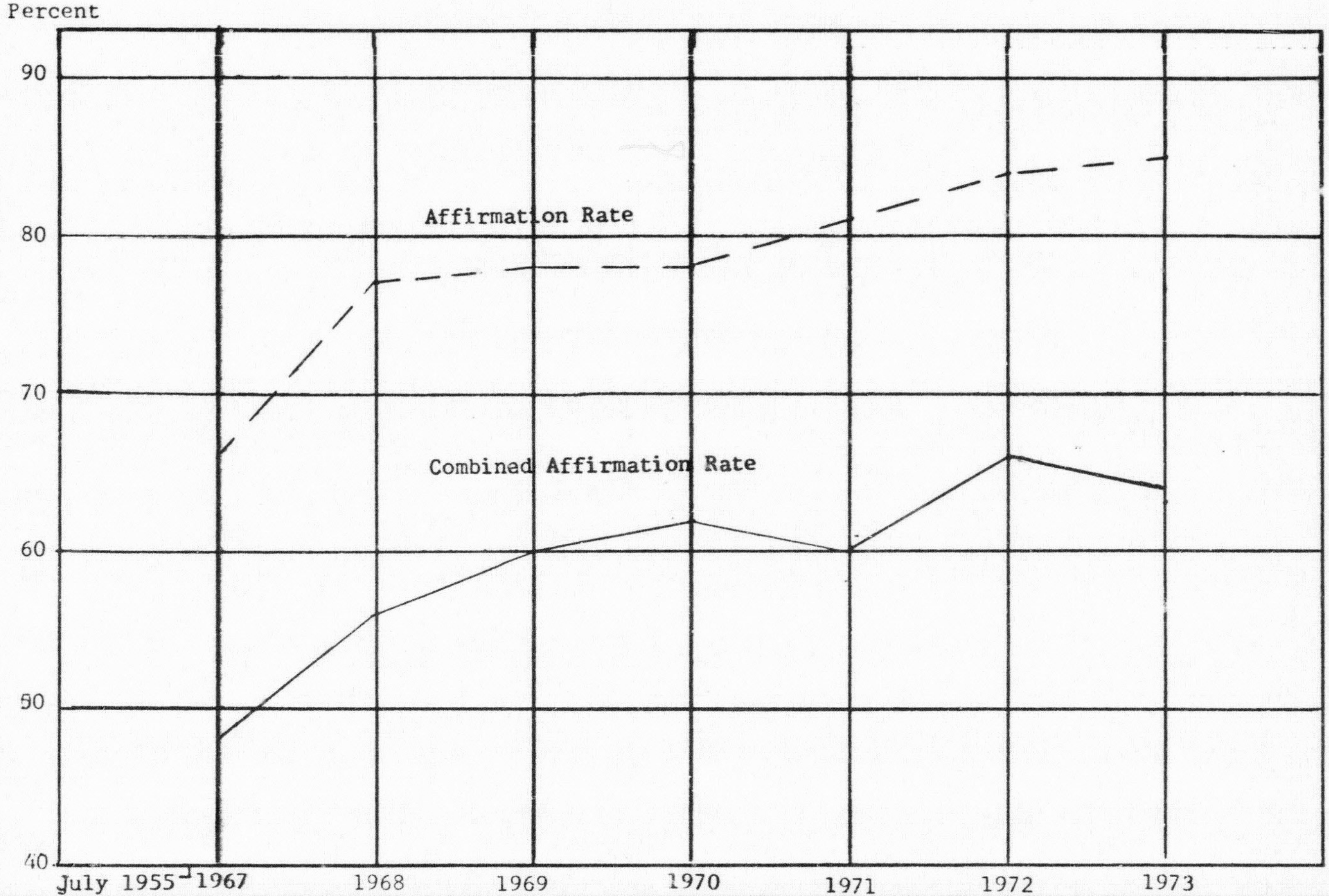
[2] Of 821 appeals, 100 were by DHEW.

[3] The U.S. Supreme Court denied certiorari in 35 of these affirmances; also in 2 dismissals and 1 remand.

[4] The Department filed petitions for certiorari in *Vernon Fields* and *Pedro Perales*. In *Fields*, the petition was subsequently dismissed by stipulation of the parties. In *Perales*, the U.S. Supreme Court reversed the lower courts and remanded the case for further proceedings. The Supreme Court in *Raymond Belcher* reversed the lower court and upheld the constitutionality of the workmen's compensation offset provision. (On the same issue, the Supreme Court denied plaintiff's petition for certiorari in *Barber Lofty* and affirmed the dismissal of plaintiff's complaint in *Russell Bartley*.) The Supreme Court vacated a lower court judgment and remanded *Radie Wright* for consideration under the Department's new procedures on suspension and termination of disability benefits.

[5] Of 91 pending appeals, 87 are appeals by plaintiffs, 4 by DHEW.

Disability Cases – District Court Actions, Affirmance Rates for Department of Health, Education, and Welfare – Calendar 1967–1973



AFFIRMATION RATE 1/	66%	77%	78%	78%	81%	84%	85%
COMBINED AFFIRMATION RATE 2/	48%	56%	60%	62%	60%	66%	64%

1/ This affirmance rate does not include Appeals Council allowances after court remand.
2/ This combined rate is based on court affirmances, court reversals, and Appeals Council allowances after court remand.

3. REMANDED COURT CASES

Staff question: ***Give a breakdown on remands by year from U.S. District Courts to the Appeals Council, showing which came on motion of the Department of HEW, the Courts' own motion, or motion of the Plaintiff. What was the ultimate disposition of these remands?***

During the period from December 28, 1972, through January 5, 1974, the Appeals Council disposed of 251 remanded court cases by issuing Appeals Council decisions affirming the prior denials. It disposed of 463 remanded court cases by reversing the prior denials. A breakdown of these affirmations and reversals shows the following:

	Affirmed	Reversed	Percent affirmed	Percent reversed
Remands on Secretary's motion	113	229	33.0	67.0
Remands on court's motion	86	145	37.0	63.0
Remands on plaintiff's motion	48	80	37.5	62.5
Remands on joint motion	3	7	30.0	70.0
Total	[1] 250	[2] 461	35.0	65.0

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[1] This is 1 less than the total shown above because card did not indicate source of remand.
[2] This is 2 less than the total shown above because card did not indicate source of remand.

Report of Court Remands Received in the Civil Actions Branch, Bureau of Hearings and Appeals, for the Calendar Quarter Ending September 30, 1973

1. General

During the quarter ending September 30, 1973, the Civil Actions Branch received 197 remands, all from District Courts. Of this number, 95 remands were at the Secretary's request; 29 at the plaintiffs' request; 8 on joint motion of plaintiffs' and the Secretary; and 65 on the initiative of the courts. The sources of remands were as follows:

1st Circuit	15	7th Circuit	4
2nd Circuit	8	8th Circuit	7
3rd Circuit	13	9th Circuit	20
4th Circuit	40	10th Circuit	11
5th Circuit	36	D.C. Circuit	2
6th Circuit	41		

Translated into terms of the Bureau of Hearings and Appeals regions the sources of remands were:

Boston	3	Dallas	28
New York	24	Kansas City	8
Philadelphia	28	San Francisco	9
Atlanta	60	Denver	3
Chicago	25	Seattle	9

2. District Court Remands

(*a*) CASES REMANDED ON MOTION OF THE SECRETARY.—Of the ninety-five cases remanded on the motion of the Secretary, ninety-one involved claims for various types of disability benefits; two for retirement and survivor's benefits; and two for health insurance benefits.

(*1*) *Disability Cases.*—(*a*) *Kerner-type development.*—Twelve cases were remanded for the primary purpose of obtaining testimony from a vocational expert. These cases fall into two categories: One, where the Appeals Council disagreed with the finding of the administrative law judge that the claimant's impairments did not prevent him from engaging in his former or similar work; and, secondly, where the administrative law judge found the claimant unable to return to his former work, but failed to obtain vocational testimony. In the latter instances, the administrative law judges preferred to substitute "administrative notice" of the existence of light or sedentary jobs in the national economy for vocational testimony or other types of vocational evidentiary input. In so doing they relied upon various court decisions which they interpreted as approving such a substitute. Several of these cases were in the Ninth Circuit, where there appears to be some question as to whether that Court of Appeals permits the taking of "administrative notice." In any event it was the feeling of the Appeals Council that the cases in which remands were sought were not suitable vehicles to seek clarification of the "administrative notice" concept. These cases all reflected non-medical factors which would make them difficult to defend. Moreover, the cases relied upon by the administrative law judges to support their position that administrative notice is permissible, either contained vocational expert testimony or the language in the opinions suggested applicability to limited factual circumstances.

(*b*) *Remands for medical development.*—The preponderance of cases remanded in this category were for the purpose of obtaining one or more consultative examinations, either alone, or together with consultative examinations related to other body systems. However, there were several cases in which remand was requested for the sole purpose of introducing medical advisor testimony, to obtain further evidence from treating sources (private hospitals, physicians, etc.) and several cases in which records from the Veterans' Administration, Workmen's Compensation Commission and private insurance companies were also deemed necessary for a more adequate record.

(*c*) *To consider newly-submitted evidence.*—As in the past, these fall into two categories: Medical evidence, usually showing either the existence of an entirely new impairment not previously reflected and a continuation of an insured status or showing an increase in severity over a pre-existing impairment; or evidence of earnings from Department records, warranting an investigation to determine whether or not the claimant is engaging in substantial gainful activity.

(*d*) *Remands requested for the purpose of reversing prior administrative action.*—In the disability insurance benefit cases in this category, the Appeals Council was of the opinion that the medical severity, considered with non-medical factors, was sufficient to warrant favorable action. In the disabled widows's claims the Bureau of Hearings Appeals Medical Staff concluded that the evidence established impairments which met or equalled in severity those contained in the Regulations.

(*e*) *Remands requested for other purposes.*—The cases in this category included remands for the purpose of determining disability during unadjudicated periods, arising from a miscalculation by the administrative law judge of the expiration date of insured status, to resolve an earnings discrepancy which would determine whether or not the claimant had a disability insured status at any time; to afford the claimant a fair hearing in light of the fact that the administrative law judge denied the claimant's request for a continuation until her attorney could appear and represent her, while at the same time asking the claimant a number of technical medical questions which were beyond her expertise to answer; and finally a childhood disability case which had been denied for failure to establish disability prior to age 18, which was remanded in order to determine whether under the 1972 Amendments disability prior to age 22 could be established.

(*2*) *Retirement and Survivors Cases.*—One case was remanded for the purpose of reversing the prior administrative action on the ground that a foreign document established that the claimant's age was as alleged on his application for Old Age Insurance Benefits, and established that he had attained retirement age. The other case was remanded for a supplemental hearing and testimony to resolve conflicting evidence in the record over the allocation of income to a husband and wife working for a family corporation. This was necessary not only for purposes of ascertaining coverage, and average monthly wage, but to determine whether or not the respective parties were also subject to deductions prior to the attainment of age 72.

(3) *Health Insurance Benefit Cases.*—Both health insurance cases were remanded to reverse the prior administrative decisions and find that the level of care received in skilled nursing facilities were not custodial, as previously determined, but involved skilled nursing services covered by the Act.

(4) *Disability and Regular Benefit Cases—Procedural.*—Two of the cases in this category were out of the San Juan, Puerto Rico hearing office and the discs were destroyed by the fire that occurred there recently. The remaining cases also involved either damaged or defective hearing discs or tapes.

(*b*) CASES REMANDED BY DISTRICT COURTS ON OWN INITIATIVE.—Sixty-one disability cases, one retirement and survivor's case and three health insurance benefit cases were remanded on the initiative of the district courts.

(*1*) *Disability Cases.*—(*a*) *Kerner-type remands.*—Notwithstanding the 1967 Amendments, vocational testimony has been rejected because the expert failed to address himself to the existence of jobs with a circumscribed grographical area, a radius of 50 miles (Puerto Rico), and the claimant's community (Pennsylvania and Kansas). Moreover, in the Kansas case, the court also rejected the vocational testimony because it was addressed to the existence of jobs where the claimant lived at the time of the hearing, but because he had moved to Kansas, directed that the testimony deal with the availability of jobs where he presently resides. In one of the Puerto Rico cases, in additon to applying the geographical test, the court held that the vocational expert must address himself not only to the ability of the claimant to engage in jobs within his physical capacity, but also to the question of whether or not he can carry out the functions of those jobs with the same degree of productivity and efficiency as non-handicapped claimants.

The remaining cases in this category were remanded for vocational testimony, where none had previously been obtained. The South Carolina Court held that the administrative law judge could not substitute "administrative notice," of employment opportunities for vocational expert testimony and remanded for vocational testimony, holding that the decisions cited by the administrative law judge as authority for taking administrative notice (*Breaux* v. *Finch*, 5th Cir., and *Chavies* v. *Finch*, 9th Cir.) are "suspect" in light of the decisions in *Garrett* v. *Richardson*, (8th Cir.) and *Orzel* v. *Richardson*, (7th Cir.). The court also noted that the brief filed by the Secretary had cited no decisions by the Fourth Circuit Court of Appeals in support of "its position" that administrative notice was permissible. A Louisiana court remanded for vocational testimony, holding that medical opinion that the claimant could do work at varying levels was not a substitute for "explicit" vocational testimony on the "availability" of suitable jobs for the claimant. An Arkansas court held that it was error for the administrative law judge to rely upon the testimony of a vocational expert offered in connection with a prior claim, where there was an "expanded" medical record. Finally, an Iowa court remanded for vocational testimony under the precedent in *Garrett* v. *Richardson.*

(*b*) *Remands for medical development.*—A large number of remands in this case reflect continuing concern by the courts over the Department's failure to consider subjective testimony of pain, when such testimony is given by both the claimant and other lay witnesses. These remands come from courts throughout the judicial system. They make it clear, almost uniformly, that they do not deny the right of the administrative law judge to refuse to give weight to subjective testimony of pain, but the decisions must reflect this fact, as well as the reasons for not accepting such testimony.

Several other remands requested "medical opinion" on the issue of whether the claimants' impairments prevented them engaging in work activity. For example, courts in Ohio, Kentucky and Tennessee relied on *Giddings* v. *Richardson* (6th Cir., 1973) for rejecting physicians' reports which were "silent" on this issue. In one Ohio case the court went so far as to state that the refusal of the physician to give an opinion on this issue "disqualifies" his report from being considered as substantial evidence to support a denial of benefits. In addition, a New York court remanded for medical opinion on whether epilepsy permitted the claimant to work, noting that the comments on this question were "too vague" to permit the court to determine whether or not the decision was supported by substantial evidence. A South Carolina remand was for a "medical opinion" on whether the claimant's mental condition rendered her incapable of work; and finally, in a disabled widow's case, the Kansas court remanded for an opinion by the consulting psychiatrist on whether or not her mental impairments met the "standards of disability."

There were a variety of other reasons for courts remanding for additional medical development. For example, the Puerto Rico court was prompted to remand, because the finding of remediability was not based on medical evidence, but on the claimant's testimony that he had relief from arthritic pain after receiving injections from his physician. The court directed that the physician be contacted for a statement on this issue. The South Carolina court noted that the vocational expert, described as a "licensed psychologist" by the court, had recommended that the claimant be treated for an anxiety reaction, and remanded for further evidence to ascertain if she had in fact undertaken such treatment and the results thereof. A Louisiana court noted that the medical advisor who had testified at the hearing was an associate of the consulting physician and remanded in order to obtain testimony from a "neutral advisor." A Kentucky court rejected a denial based on the claimant's demonstrated capacity for substantial gainful activity on a Work Relief Program, and remanded for additional evidence and findings on whether or not his diagnosed impairments rendered him incapable of substantial gainful activity. An Ohio remand was for the purpose of obtaining a current psychiatric examination and to have the examining physician state specifically whether or not (1) the claimant is presently under a severe mental handicap and (2) if so, can it be related back to 1952, when at age 30, he was last insured. A Texas court refused to accept an onset based on the date of an orthopedic examination where the claimant had suffered a back injury several years prior thereto, and remanded for the purpose of obtaining reports relating to his condition at the time of, or immediately following, the injury.

(c) *Cases remanded for reasons other than above.*—The Massachusetts court rejected the finding that a disability insurance benefit claimant was not without fault in causing an overpayment of benefits, simply because she had the intellectual capacity to understand the requirements of reporting her return to work or should have known of the responsibility to report this fact. The court held, in addition to the ability to understand or know her obligation, the elements of sincerity and good faith in attempting to comply with the reporting requirements should have been considered. The court noted that this is essentially a credibility issue and only the administrative law judge is in a position to make it, and remanded for such findings. In an opinion very critical of the legibility of the transcript, a Mississippi court remanded for a better record and for further evidence and findings on the expiration date of insured status, before it would rule on the Secretary's motion to dismiss on the ground of res judicata.

(2) *Retirement and Survivors Cases.*—A New York widow's case was remanded for a finding on whether North Carolina courts would set aside a divorce decree on the basis of claimant's allegations that the wage earner obtained the divorce from her through fraud.

(3) *Health Insurance Benefit Cases.*—A New York claimant had been denied coverage for treatment in a skilled nursing facility because she had been in a section of the facility which was specifically not covered by medicare. The court reversed and held, in effect, that the location in the facility was not determinative particularly where she could not be moved into the medicare section because of construction problems. It remanded for findings on whether she required and received skilled nursing care. The Nebraska court remanded a level of care case for an interpretation of medical records based on medical records prepared by nurses on a daily basis, by "someone skilled in the medical arts." A Louisiana court remanded for a second time an emergency services case. The emergency had been conceded, but on the prior remand it was determined that there was at the time of the emergency, a participating hospital equally accessible to the claimant as the non-participating hospital where he sought treatment. The court held that accessibility of a participating hospital was not the only criterion for determining reimbursement, and remanded to determine whether or not the participating hospital was "equipped to handle the emergency."

(*c*) Cases remanded on plaintiffs' motions.—Twenty-seven disability and two retirement and survivors cases were remanded on plaintiffs' motions.

(*1*) *Disability Cases.*—The vast majority of plaintiff's motion remands are silent except to state that either the plaintiff has submitted additional evidence to the court, which the courts feel established good cause for granting their motion to remand or, in the alternative, they have made representations to the court that such additional evidence exists. Nevertheless it should again be noted that in a large number of these cases the courts suggest that they were prompted to grant the plaintiff's requests because they lacked counsel at the administrative hearing. In one case, the court specifically noted that it was remanding notwithstanding the fact that the claimant was represented by counsel, but felt that the administrative law judge did not give the claimant a full and fair hearing by failing to obtain relevant evidence which was known to be available. Maryland and Virginia courts rejected arguments by claimants that they were denied due process because of lack of counsel. Nevertheless, they pointed out that the administrative law judges handled the case in a "cursory" manner, even commenting on the relative brevity of the hearings. The Maryland court noted that "where plaintaff is unfamiliar with the process of organizing and presenting a case to an administrative agency and proceeds to a hearing before that agency unaided by counsel, a special duty devolves upon that agency * * * to insure that plaintiff receives a full and fair hearing. This is especially so where the proceedings is non-adversary. This special duty may require, in appropriate instances, the hearing examiner to make an affirmative effort to probe, inquire and explore the relevant facts surrounding the claim. This does not mean that a hearing examiner must turn every stone or act as an advocate for every unrepresented claimant," The court then went on to point out that in this case the administrative law judge was made aware by the claimant at the hearing of additional evidence which bore materially on his claim, but without stating a reason in his decision or otherwise, failed to seek such evidence. In another Virginia case, the court was prompted to grant the motion for remand on the basis of submittal of a new psychiatric report, because in the court's opinion this would resolve the conflict created when one psychiatrist diagnosed the claimant as having a personality disorder with lack of motivation for work, and another felt he suffered from severe psychoneurosis. The court rejected the argument put forth by the Department that the new evidence related to his condition more than three years after the expiration of his insured status, and observed that the evidence of record established that current severity could be related back to the appropriate period.

(*2*) *Retirement and Survivors Benefit Cases.*—The South Carolina court granted a motion to remand on the basis of letters from the claimant's son to her, which purported to show that she was receiving at least one-half of her support from him at the time of his death, and might therefore establish entitlement to parent's insurance benefits. The District of Columbia court remanded a retirement benefit case for consideration of school and census records as evidence of age.

(*d*) Cases remanded on joint motion of plaintiff and defendant.—All of the cases in this category involved claims for disability benefits. In each instance, the Appeals Council was apprised of the fact that the claimants had additional medical evidence to submit and joined with the claimant to have the case remanded for consideration thereof.

3. Disposition of Remanded Court Cases by the Appeals Council

During the calendar quarter ending September 30, 1973, the total number of post-remand decisions were 145.[1]

(*a*) Reversing decisions.—84.

(*1*) *Disability Cases*—74.[2]

(*a*) 59 cases—New or additional medical evidence resolved questions as to the extent, severity or remediability of impairments. Non-medical evidence, including job data, was also obtained.

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[1] Of these, 84 were disposed of by Appeals Council decision only, and 61 were Appeals Council decisions following recommended administrative law judge's decisions.

[2] It will be noted that more than one factor appeared in practically every case, thus giving a total more than double the number of cases involved.

(*b*) 27 cases—Consultative examinations were obtained.

(*c*) 0 cases—Consultative medical examiner testified at post-remand hearings.

(*d*) 1 case—Private physician testified at post-remand hearing.

(*e*) 17 cases—Vocational consultants testified at post-remand hearings.

(*f*) 10 cases—Medical Advisors testified at post-remand hearings.

(*g*) 8 cases—Reversed on the record.

(*2*) *Regular Benefit Cases*—5.—Development undertaken in the case of *Linda Newell* disclosed that she was in fact a full-time student in high school, as alleged, under the definition contained in an amended claims manual section. The prior denial in the case of *Louis Russo* was reversed on the record, since the evidence of record established that a foreign document, containing a date of recordation at or near the time of birth, established that he had attained retirement age as of the date of his application. Evidence obtained on remand in the case of *Edry Pugh* indicated that she and the deceased wage earner had been living together and had held themselves out to the public as man and wife, and therefore under Texas law, an intent to marry could be inferred and the existence of a common-law marriage was established. Consequently, the children of this marriage were found to be legitimate and entitled to benefits. Child's benefits were paid under the 1972 Amendments in the case of *Maud Jennings* where the child was adopted after the wage earner became entitled to disability insurance benefits, but was living with and receiving one-half support from him for one year prior to the month of his entitlement. Evidence obtained on remand in the case of *Josephine Fenoglio* disclosed that for one year prior to the entitlement of her former husband, the wage earner, she was receiving one-half of her support from him and therefore was entitled to divorced wife's benefits.

(*3*) *Health Insurance Benefits*.—The cases of *Ella Singleton* and *Anna Kirshner* were reversed on the record, both involving the level of care in skilled nursing facilities. In both instances, the Appeals Council felt that there was no rebuttal evidence to overcome the opinions of the respective treating physicians and the Utilization Review Committees to the effect that skilled nursing services were required, in the case of *Singleton*, to treat a fractured hip with concomitant physical therapy; and in *Kirshner*, treatment for a severe psychiatric impairment. In *Roy Williams*, additional evidence received from the claimant's physician and the Utilization Review Committee of a county hospital disclosed that continued hospitalization of the claimant was necessary because he kept going into congestive heart failure. *Frank Ziolkowski* was found entitled to inpatient hospital benefits on the basis of information that he required the constant availability of physicians, skilled medical services and complex equipment ordinarily found in a hospital and not found elsewhere, in order to treat a bowel obstruction, cardiac ischemia and hypertrophy and cerebral hemorrhage. *Mary Almos* was found entitled to benefits for treatment in a skilled nursing facility, because the physical therapy which she received was administered under the supervision of a physician by a qualified physical therapist throughout her entire stay at the facility, and such therapy was given twice a day.

(*b*) AFFIRMING DECISIONS.—61.

(*1*) *Disability Cases*—56.—

(*a*) 36 cases—New or additional medical evidence resolved questions as to extent, severity or remediability of impairments. Nonmedical evidence, including job data, was also obtained.

(*b*) 21 cases—Consultative medical examinations were obtained.

(*c*) 0 cases—Consultative medical examiner testified at post-remand hearings.

(*d*) 0 cases—Private physician testified at post-remand hearings.

(*e*) 12 cases—Vocational consultants testified at post-remand hearings.

(*f*) 7 cases—Medical advisors testified at post-remand hearings.

(*2*) *Regular Benefit Cases*.—On remand the Appeals Council obtained information to the effect that the natural mother of *Loretta McCurry* refused to give her up for adoption until long after the wage earner became entitled to retirement benefits. This evidence, considered with the testimony of the claimant herself that the natural mother "just wouldn't give over the children until 1969," or shortly before the date of the legal adoption, was considered to be cogent evidence that an equitable adoption had not taken place within twenty-four months of the wage earner's entitlement to benefits. The Appeals Council found that although the deceased wage earner was contributing to the support of the children of *Virginia Ellison*, she had produced absolutely no evidence to sustain the burden of proving that he was the biological father of the children and since she was married to another man at the time of their births, benefits were denied. *Mary Recide* was receiving benefits as a "de facto" widow until June 1969, at which time it was learned that the deceased wage earner was survived by a legal widow and benefits to the claimant were terminated. The evidence obtained on remand confirmed the validity of the prior decision. The District of Hawaii court had remanded this case under the decision in *Goldberg v. Kelly*, holding that it would not affirm the termination of benefits until the claimant had received a "formal hearing" in accordance with the Supreme Court decision in that case.

(3) *Health Insurance Benefits*—2.—The cases of *Sidney Stern* and *William Whitman* were remanded because of defective discs, and although the attorneys for the respective claimants were requested to submit additional evidence on remand, they failed to do so, and the prior administrative decisions were affirmed without obtaining any additional evidence.

4. Relative Period During Which Remand Orders have been Received in the Cases Involving the 145 Dispositions

(*a*) DECISIONS IN CASES IN WHICH THE REMAND ORDERS WERE RECEIVED IN THIS CALENDAR QUARTER.—Eight cases in which a favorable decision was issued.

(*b*) DECISIONS IN CASES WHERE THE REMAND ORDERS WERE RECEIVED IN PRIOR QUARTERS.—137.

Staff question: ***What was the median time for remands disposed of by the Appeals Council in fiscal year 1973?***

The median time for court remands was 222 days (of which the median for those remanded at the request of the Department of Health, Education, and Welfare was 195 days; at the request of the plaintiff, 239 days; and for those ordered remanded by the court without such request of the parties, 245 days). The number of median days is based upon the period between the date of the court remand order and the date of the final decision of the Appeals Council in a court-remanded case. It is not possible to give a further breakdown, by court and HEW category.

4. PROBLEMS OF LITIGATION

Report of General Counsel Study Group

THE HANDLING OF DISABILITY LITIGATION

Disability Litigation Task Force

Donald A. Gonya, Deputy Assistant General Counsel, Social Security Division.
John M. Stokes, Regional Attorney, Dallas.
Carl H. Harper, Regional Attorney, Atlanta.
Stephanie W. Naidoff, Regional Attorney, Philadelphia.
Jerome T. Levy, Deputy Regional Attorney, New York.

Part I—Growth and Standards

I. *Background*

Before analyzing in detail the dimensions of Title II litigation, a brief review of the present procedures for handling such litigation would seem helpful.

A. Judicial Review of Administrative Hearing Decisions—Procedures for Handling.—Section 205(g) of the Social Security Act, 42 U.S.C. 405(g), provides that an individual may secure judicial review in a United States District Court of a final decision of the Department concerning his social security benefits. The court's action is limited to a review of the record to determine whether the decision is supported by substantial evidence. Thus, this type of judicial review is not available unless the individual has first obtained a decision by the Appeals Council of the Bureau of Hearings and Appeals which serves as the final decision of the Secretary for purposes of section 205(g). If the Appeals Council dismisses the action, or denies review, or grants review and renders a decision adverse to the claimant, he may file an action for judicial review. 20 C.F.R. 404.951.

A claimant obtains judicial review by filing an action against the Secretary in the U.S. District Court where the claimant resides or, if he is not a resident of the United States in the U.S. District Court for the District of Columbia. The Deputy General Counsel's office accepts service on behalf of the Secretary and sends the papers to the Social Security Division. The Division notifies the SSA Bureau of Hearings and Appeals (BHA) and requests certified copies of the administrative record which must be filed with the court for review.

In a certain percentage of cases we ask the U.S. Attorney to move to dismiss, usually because administrative remedies were not exhausted, the action was not timely filed or the decision complained of was governed by a prior administrative decision which had become final or *res judicata* of the current issue.

In the vast majority of cases when BHA transmits the record to the Office of the General Counsel, Social Security Division it recommends that the case be defended on the record. After an attorney goes over the record occasionally the Litigation Branch in the Social Security Division finds it necessary to recommend that the case be remanded to SSA because the decision appears not to be defensible. Generally, however, the first action we take after review of the record is to prepare an answer for filing by the U.S. Attorney. The answer is prepared in the Social Security Division and forwarded directly to the U.S. Attorney with a copy to the Regional Attorney.

The Department of Justice represents the Secretary before the courts in benefit litigation, but we are much more deeply involved than in the case of general litigation where usually a department confines its litigation activities to supplying needed information to the Civil Division at Justice and to preparing an outline of the legal considerations. In other cases the Civil Division at Justice usually works with the U.S. Attorney's office in the preparation and filing of the necessary papers with the court. In social security benefit litigation the Division or the regional attorney (depending on assignment of the case as described below) prepares in final legal briefs or memoranda for signature and filing by the U.S. Attorney. In effect, at the district court stage, we perform a brief writing function which for other types of litigation normally would be performed by the central office of the Civil Division in Justice, working with the U.S. Attorney.

After the answer is filed, the case usually is brought to decision through the filing of a motion for summary judgement together with a memorandum in support of the motion. The memorandum is the brief which provides legal argument in support of the secretary's decision. To assist us in the preparation of the brief, the Bureau of Disability Insurance, Court Case Staff, provides us with a statement of facts in disability cases which contains a summary of the medical and vocational evidence of record. This factual is forwarded to the Regional Attorney at the time the case is assigned for briefing. Most cases are assigned to regional attorneys for the preparation of the memorandum and forwarding to the U.S. Attorney, but about 10 percent of these memoranda are prepared in the Social Security Division because unusual issues make central office handling desirable or the case can be handled by law students in the Division or by the two personnel from the Bureau of Disability Insurance who are usually on rotating detail to the Division as a training and coordination mechansim.

B. Judicial Review of Administrative Hearing Decisions—Volume.—The workload for judicial review of administrative decisions under 42 U.S.C. 405(g) can be statistically demonstrated perhaps more clearly than any other work of the office. Another characteristic of this function is that we are powerless to control the volume and have only limited flexibility with respect to the amount of services to be provided and the timing of the work. A final important factor is the apparent inevitability of a yearly increase in judicial review of social security beneficiary cases coupled with an expected deluge of black lung and supplemental security income (SSI) cases which by the end of fiscal 1975 will greatly exceed the volume we now are handling. These concerning but inescapable facts can be gleaned from the data outlined below.

II. *Growth of Title II Litigation*

To understand fully the impact which Title II litigation has had on the Social Security Division and the regions, a review of the growth of the litigation rate over a period of years is necessary. For purposes of this analysis as well as studying growth of staff, expansion in other offices, etc., we have selected the calendar years from 1968 through 1973.

However, we are confident that had we chosen to go back even further in the 1960's the same type of steady litigation growth would have been revealed. In depicting this growth for the six year period under review, we have analyzed the number of new cases filed for each of the years as well as the number of briefs released by the regions and the Social Security Division during this period. Results of these studies disclose the following:

Region	1968		1969		1970[1]	
	New cases	Briefs	New cases	Briefs	New cases	Briefs
I	22	35	27	68	33	24
II	47	34	87	28	106	36
III	298	221	525	299	393	329
IV	250	88	304	97	339	194
V	121	47	170	93	165	141
VI	137	87	165	113	117	195
VII	33	33	48	38	62	67
VIII	21	19	16	17	24	16
IX	102	67	130	81	107	85
X					26	20
Social Security Division		260		367		195
Total	1, 031	891	1, 472	1, 201	1, 372	1, 302

[1] Kentucky and North Carolina, which have a substantial volume of disability litigation, were transferred to Region IV. Puerto Rico was transferred to Region II.

Region	1971		1972		1973	
	New cases	Briefs	New cases	Briefs	New cases	Briefs
I	34	41	43	34	48	15
II	192	86	251	123	337	263
III	260	232	445	205	455	265
IV	442	308	538	314	710	438
V	273	137	291	188	287	169
VI	254	117	298	243	341	279
VII	36	44	40	93	75	49
VIII	18	26	23	9	30	19
IX	117	67	144	115	181	92
X	49	38	62	54	68	60
Social Security Division		212		244		204
Total	1, 675	1, 308	2, 135	1, 622	2, 532	1, 851

The total number of social security cases pending as of December 31 of each of the above years also adds further insight into the constantly increasing social security litigation workload.

	Cases pending
1968	1, 751
1969	2, 370
1970	2, 769
1971	3, 148
1972	3, 775
1973	4, 033

Of the 4,033 cases pending on December 31, 1973, the regional distribution of this pending workload is as follows:

Region:	
I	92
II	616
III	683
IV	1, 099
V	527
VI	503
VII	109
VIII	42
IX	269
X	93
Total	4, 033

The figures cited above can be offered in many different ways to highlight the proliferation of social security cases requiring the services of this office over the last six years. None, however, seems more direct than the simple fact that the number of cases filed in 1968 (1,031), more than doubled by 1972 (2,135). Yet, in the face of such staggering growth, the average size of staff in regional attorneys' offices stayed nearly the same during this period. Combined, we have the almost unbelievable circumstances of an additional thousand cases to defend in 1972 as compared to 1968, an increase in brief production of 731, the addition of programs to service such as Medicare, Medicaid, Civil Rights, etc. all occurring at a time when regional staff decreased in number. The outcome of such disastrous circumstances has, of course, been that the Social Security Division and the regions have been absorbing the increasing litigation load partially through diversion of attorneys from other work and partly through change in methods resulting in an increase in production per attorney.

Unfortunately, another situation resulting from this heavy volume of work has been a constantly increasing backlog in the number of cases awaiting briefing. Such a backlog contributes to a delay in the court action which must be taken on the plaintiffs' claim; a delay which is bringing increasing criticism from the public and from the courts. In reacting to these delays some courts have set time limits within which we must file our answer, motions, and brief. These deadlines can be met only by delaying the progress of cases in other courts. The backlog of cases assigned, ready for briefing, but unbriefed has continued to increase in the same overwhelming proportions as has the number of cases filed. The fololwing data reflect the expanding backlog:

July 1968	135
July 1969	141
July 1970	162
July 1971	322
July 1972	455

As of December 31, 1973, this backlog of cases assigned but not briefed had reached a staggering figure of 635 which represents approximately 15% of the more than 4,000 cases pending as of that date. This backlog of cases to be briefed as of that date was made up of the following number of cases by region and Division.

Region:	
I	24
II	64
III	37
IV	157
V	99
VI	90
VII	14
VIII	15
IX	53
X	12
Social Security Division	70
Total	635

The backlog in some of the regions with a high volume of litigation is obviously in need of immediate attention. However, in analyzing the backlog existent in each of the offices as of December 31, 1973, it is also significant to note that while the offices with a smaller litigation worklog (Regions I, VII, VIII, IX, and X), naturally have a smaller backlog, nevertheless even these five offices have difficulty in meeting timely social security litigation responsibilities. This problem as it exists in the five offices identified above can perhaps best be depicted by identifying the number of new cases filed in those regions in 1973 and comparing it with the December 31, backlog present in each of these offices.

	1973 new cases	Dec. 31, 1973 backlog	Ratio of backlog to new cases (percent)
Region:			
I	48	24	50
VII	75	14	18
VIII	30	15	50
IX	181	53	29
X	68	12	17

Thus, we believe that the above data not only reflect a major problem in terms of the volume of backlog in the five larger offices but, in addition, even in the offices with a much lower litigation rate the backlog of cases as compared to the number of cases being filed in these regions is also in need of attention. The need for management to address itself to the serious problems posed by the rapidly increasing backlog becomes even more acute in light of the quickly approaching black lung workload which in large part will arise in three of the regions (Atlanta, Chicago, and Philadelphia) which already have a high volume of disability litigation.

III. *Growth of Regional Attorneys' Staff*

While a review of the growth of the Social Security litigation workload reveals a dramatic increase over the six year period we have examined, a review of the number of personnel assigned to the regions during the same period discloses a staffing pattern that has not kept pace with the rise in litigation workload facing regional attorneys' offices during these years. For example, our studies reveal that of the nine regional attorneys' offices in existence in 1968, five offices had a lower number of attorneys assigned in 1973 than they did in 1968. One other region, Region III, had the same number in 1973 as 1968. Yet, in the intervening four years, that office also operated with less lawyers than it did in 1968. The same is true for New York and Atlanta, which show slight increases in attorney staff in 1973 as compared to 1968. Again, however, both those offices were forced to operate with a lesser number of attorneys during certain years between 1968 and 1973. The following chart outlines the various attorney and clerical staffing situations for each of the ten regional attorneys' offices for the six year period we have picked to analyze.

	1968		1969		1970	
	Attorney	Clerical	Attorney	Clerical	Attorney	Clerical
Region:						
I	4.6	4.0	4.4	3.1	4.0	2.4
II	5.5	3.9	4.0	3.7	3.2	3.9
III	8.0	4.8	7.0	5.0	5.7	4.8
IV	5.8	4.9	5.3	5.0	5.2	5.0
V	3.3	3.0	4.0	3.0	3.8	2.6
VI	7.0	4.6	7.0	5.0	6.7	5.0
VII	3.4	3.0	3.0	3.0	3.0	2.9
VIII	4.6	3.4	4.6	3.6	5.0	4.0
IX	6.0	3.6	6.2	3.5	6.5	4.3
X						

	1971		1972		1973	
	Attorney	Clerical	Attorney	Clerical	Attorney	Clerical
Region:						
I	3.4	2.1	2.6	2.1	3.1	2.0
II	4.7	4.5	6.7	4.9	6.0	5.0
III	6.7	4.9	6.3	5.2	8.0	7.0
IV	6.9	5.0	7.4	5.6	8.0	7.3
V	4.6	3.5	5.0	4.0	5.0	3.1
VI	6.6	5.0	5.7	3.9	5.0	4.1
VII	3.2	2.9	2.6	2.8	3.1	2.4
VIII	5.0	3.0	3.7	3.1	4.0	3.6
IX	7.1	4.9	7.1	5.0	5.4	5.0
X	2.7	2.0	3.0	2.1	3.0	3.0

A summary of the average number of attorneys and clerical personnel assigned to these offices during subject period indicates clearly that staff growth has not been consistent with the degree of increase in social security litigation. Moreover, in highlighting the rise in litigation caseloads as compared to the lack of growth in staff, it must also be pointed out that since 1968 major new programs also required the legal services of the regional attorneys' offices, namely, Medicare, Medicaid, Civil Rights, Federal Medical Care Recovery, as well as a rising volume of SRS, Health and Education work. All such data add up to an inescapable conclusion; we simply have not experienced the growth in staff necessary to keep up with constantly increasing workloads that have been imposed on us by social security litigation. The chart referred to above also indicates the total number of attorneys and clerical personnel assigned to the regions for the respective calendar years.

	Attorney	Clerical
1968	48.2	35.2
1969	45.5	34.9
1970	43.1	34.9
1971	50.9	37.8
1972	50.1	38.7
1973	50.6	42.5

By way of explanation it must also be pointed out that the slight increase shown in both attorney and clerical staff for 1971 and years thereafter reflects, in part, the addition of the Seattle office to the regional organization.

This committee believes that the facts speak for themselves and that while we strongly recommend that measures be adopted to streamline the handling of disability litigation wherever possible and appropriate, we also believe that management must recognize that a staff which was essentially the same in number in December, 1973, as it was in 1968, was not equipped with the manpower necessary to do the job. We would strongly urge that the kind of data and information furnished herein as to the disproportionate growth in litigation as compared to personnel be used to the maximum degree possible in any future discussions the General Counsel may have with the Comptroller and the Social Security Administration as to possible staff augmentation that may be necessary in the future to handle litigation. The committee also believes that the growth of disability litigation as described herein should be brought to the attention of the Justice Department should any questions be raised by that agency as to any changes which the General Counsel may direct in the methodology for doing briefs.

Staff question: ***How does the Federal Rule requiring an answer by the Government within 60 days of the filing of a Court appeal affect disability litigation?***

Under Section 205(g) of the Social Security Act, as amended, a dissatisfied claimant for social security benefits may bring a suit against the Secretary of Health, Education, and Welfare in Federal district court for review of the administrative record in his case. This section of the Act further provides that as a part of his answer to the complaint, "the Secretary shall file a certified copy of the record" in the case, "including the evidence upon which the findings and decision" are based.

Rule 12(a) of the Federal Rules of Civil Procedure provides that the United States or an officer or agency thereof shall serve an answer to the complaint within 60 days after service upon the United States Attorney.

Because of the time-consuming task of compiling the required records and preparing the proposed answers for the U.S. Attorneys, it has been the practice to request the district courts for extensions of time. Until comparatively recently, in most cases, extensions of 60 days were routinely granted under Rule 6(b) of the Federal Rules of Civil Procedure. There are now nine district courts which are considered "priority jurisdictions" because they will either rarely grant extensions or will only grant extensions of less than 60 days.[1]

The Office of the General Counsel has indicated that they would like to have the court transcript within 39 days of service on the U.S. Attorney to allow for sufficient time in which to prepare a proposed answer, etc., if the answer and transcript are to be filed within the 60 days. Special procedures to meet this deadline in priority cases have been instituted, and we have generally been able to meet it. However, this has delayed work on remanded cases (in which some courts are also placing time limits), and on new court cases arising in non-priority jurisdictions. It will not be possible to meet the 60-day deadline in all new court cases without a vast increase in manpower and costs.

We are currently receiving over 250 new court cases a month. The new court case workload is expected to double in fiscal year 1975 because of civil actions that will be filed under title IV of the Federal Coal Mine Health and Safety Act, as amended, and title XVI of the Act. A number of the district courts in priority jurisdictions have issued their rulings limiting the granting of extensions comparatively recently; we, therefore, believe there is a strong possibility that other jurisdictions will adopt similar restrictions. Thus, with an increase in both caseload and the number of districts imposing time restrictions, this Bureau (and OGC) may face filing deadlines that cannot be met.

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[1] Judges in two other districts have questioned the practice of routinely granting the Secretary extensions of time. For the time being at least, these jurisdictions are also considered priority jurisdictions.

4. Rehabilitation

A. INTRODUCTION

Congress has always intended that a rehabilitation program play a major role in the disability insurance program. In 1954 Congress passed an earnings freeze for social security purposes for disabled workers and a provision was included in this law which required referrals of disabled workers to State vocational rehabilitation agencies. To stress rehabilitation in the disability program Congress specified that wherever possible the State vocational rehabilitation agency should be the contracting agency to make disability determinations. When the social security amendment providing for monthly cash benefits for disabled workers was passed in 1956, a referral provision similar to that in the 1954 amendments was included. Moreover, benefits could be withheld or reduced if the disability beneficiary refused rehabilitation service without good cause.

Through the years Congress has tried to encourage rehabilitation by enacting provisions which would make return to work easier for the disabled worker. Several such provisions are: A trial work period for the worker to try new skills, elimination of the waiting period for recurring disability to encourage the worker to return even to short-term employment, and elimination of the waiting period for former childhood disability beneficiaries who again become disabled.

In the Social Security Amendments of 1965 (Public Law 89–97) Congress provided that disability insurance trust fund money could be used to reimburse the States for the cost of rehabilitation services to disability beneficiaries. Under this provision the total reimbursement could not, in any year, exceed 1 percent of the amount of social security disability benefits for the previous year. The Senate Finance Committee report (404 pt., 1 p. 103) stated that only about 3,000 disability beneficiaries were rehabilitated in any previous year mainly because of the lack of State funds to match the available Federal funds. Congress was assured by the Department of Health, Education, and Welfare that the money spent on rehabilitation services would actually result in a savings to the disability trust fund as a result of the disabled beneficiaries who would be returned to covered employment by these services. Given a similar assurance in 1972 by the HEW that the trust fund was realizing savings due to the money spent on vocational rehabilitation, Congress increased the authorization for use of trust fund money to 1.25 percent for fiscal year 1973 and to 1.5 percent for fiscal year 1974 and subsequent years.

In the supplemental security income program a provision was included authorizing the Secretary of HEW to pay out of general revenues the full cost of vocational rehabilitation services provided to SSI recipients who qualify for payments by reason of a disability. A referral mechanism was provided which was similar to that in the social security program. All such recipients under 65 years old are to be referred to the State vocational rehabilitation agencies for rehabilitation services. Like social security title II beneficiaries, SSI recipients will lose part or all of their benefits if they refuse vocational rehabilitation services without good cause.

B. Trust Fund Rehabilitation Terminations

TABLE 51.—*Trust fund rehabilitants terminated from benefit rolls, 1967–73*

Fiscal year	Disabled worker beneficiaries	Disabled child beneficiaries	Disabled widow beneficiaries	Total	Cumulative
CUMULATIVE STATISTICS					
1967	165	5		170	170
1968	1,030	38		1,068	1,238
1969	2,659	140		2,799	4,037
1970	2,939	139		3,078	7,115
1971	2,335	(1)		2,335	9,450
1972	2,408	(1)		2,408	11,858
1973	2,383	211	3	2,597	14,455

SELECTED DATA THROUGH JUNE 1973

A. Number of terminations (some of whom may have returned to the disability or retirement rolls):	
(1) Wage earners	13,919
(2) Wage earners with auxiliary beneficiaries	8,658
(3) Auxiliary beneficiaries	30,534
(4) Disabled adult children and disabled widows(ers)	536
(5) Total disabled beneficiaries	14,455
B. Benefit payments terminated:	
(1) Average monthly benefit paid wage earners	$196
(2) Average monthly benefit paid to family groups (excludes wage earners with no auxiliaries)	$358
(3) Average monthly benefit paid to wage earners and family groups	$293
C. Miscellaneous:	
(1) Average age of terminated wage earners	40
(2) Average age of terminated disabled adult children	26
(3) Average number of terminated auxiliary beneficiaries per family group	3.5

[1] Not available.

Characteristics of 1969 Rehabilitants and Terminees

The records of 13,450 individuals reported rehabilitated in fiscal year 1969 were reviewed to determine their status as of December 1970.

1. Disabled beneficiaries reported rehabilitated with trust funds were found to have been terminated at a 45-percent rate as contrasted with a 25-percent rate for nontrust-fund rehabilitations.

2. Trust fund rehabilitants had been terminated and remained off the rolls at a 41-percent rate versus a non-trust-fund rate of 22 percent.

3. Of the rehabilitants with any earnings, 56 percent were financed with trust funds as compared to 39 percent financed with non-trust-fund money. Of those rehabilitants with earnings of $5,000 or more, 21 percent were trust fund financed and 10 percent non-trust-fund financed.

TABLE 52.—*Disabled worker beneficiaries rehabilitated in fiscal year 1969 and terminated*

	Number rehabilitated	Terminated	Percentage of terminations
Total	13, 450	4, 572	34. 0
Sex:			
Men	10, 487	3, 838	36. 6
Women	2, 963	734	24. 7
Age in 1969:			
Under 30	774	401	51. 8
30 to 34	1, 022	542	53. 0
35 to 39	1, 333	704	52. 8
40 to 44	1, 742	816	46. 8
45 to 49	1, 982	788	39. 7
50 to 54	2, 087	637	30. 5
55 to 59	2, 086	465	22. 2
60 and over	2, 349	212	9. 0
Unknown	75	7	9. 3
Race:			
White	11, 261	3, 841	34. 1
Negro	2, 063	668	32. 3
Other	126	53	42. 0

Table 53.—*Disabled-worker beneficiaries rehabilitated (with trust funds) in fiscal year 1969: recovery and other benefit termination experience, by trust fund status and social characteristics, December 1970* [1]

Social characteristics	Number	Percent distribution						
			Recovery terminations [2]					
		Total	Total	Termination continuing	Return to disability	Age 65	Death	Continuing disability
Total	6,194	100	44.7	40.9	3.8	1.1	2.5	51.6
Sex:								
Men	5,027	100	46.8	43.0	3.8	1.2	2.7	49.2
Women	1,167	100	35.4	31.5	3.9	.9	1.5	62.0
Age in 1969:								
Under 30	421	100	60.1	58.0	2.1	----------	.7	39.2
30 to 34	590	100	60.5	57.3	3.2	----------	1.0	38.5
35 to 39	777	100	58.6	53.5	5.1	----------	1.2	40.2
40 to 44	929	100	54.4	49.9	4.5	----------	1.6	43.9
45 to 49	975	100	46.0	41.0	5.0	----------	1.7	52.2
50 to 54	989	100	38.4	35.2	3.2	----------	3.0	58.5
55 to 59	847	100	31.4	27.9	3.5	----------	5.9	62.7
60 and over	643	100	15.7	13.4	2.3	10.9	3.4	70.0
Unknown	23	100	8.7	----------	8.7	----------	13.0	78.3
Race:								
White	5,308	100	44.9	41.2	3.7	1.2	2.5	51.4
Negro	840	100	42.9	38.1	4.8	.8	2.4	53.9
Other	46	100	47.9	45.7	2.2	----------	2.2	50.0

[1] Based on vocational rehabilitation reports received during fiscal year 1969.

[2] Disabled person ceased to meet medical standards for disability, or is engaged in substantial gainful activity.

Table 54.—*Disabled-worker beneficiaries rehabilitated (without trust funds) in fiscal year 1969: recovery and other benefit termination experience by social characteristics, December 1970* [1]

Social characteristics	Number	Percent distribution						
			Recovery terminations [2]					
		Total	Total	Termination continuing	Return to disability	Age 65	Death	Continuing disability
Total	7,256	100	24.9	21.8	3.1	2.4	3.6	69.1
Sex:								
Men	5,460	100	27.2	24.0	3.2	2.5	3.9	66.4
Women	1,796	100	17.9	15.1	2.8	2.2	2.6	77.3
Age in 1969:								
Under 30	353	100	41.9	39.4	2.5	----------	2.0	56.1
30 to 34	432	100	42.8	39.8	3.0	----------	.7	56.5
35 to 39	556	100	44.8	39.4	5.4	----------	.7	54.5
40 to 44	813	100	38.2	34.3	3.9	----------	1.4	60.4
45 to 49	1,007	100	33.7	29.6	4.1	----------	2.4	64.9
50 to 54	1,098	100	23.4	20.2	3.2	----------	4.4	72.2
55 to 59	1,239	100	16.1	13.7	2.4	----------	4.8	79.1
60 and over	1,706	100	6.5	4.9	1.6	10.3	5.7	77.5
Unknown	52	100	9.6	----------	9.6	----------	13.5	76.9
Race:								
White	5,953	100	24.5	21.4	3.1	2.5	3.7	69.3
Negro	1,223	100	25.2	22.6	2.6	2.4	3.4	69.0
Other	80	100	38.8	37.5	1.3	1.3	2.5	57.4

[1] Based on vocational rehabilitation reports received during fiscal year 1969.

[2] Disabled person ceased to meet medical standards for disability, or is engaged in substantial gainful activity.

TABLE 55.—*Disabled-worker beneficiaries rehabilitated (with trust funds) in fiscal year 1969: recovery and other benefit termination experience, by trust fund status and family characteristics, December 1970* [1]

Family and benefit characteristics	Number	Percent distribution						
			Recovery terminations [2]					
		Total	Total	Termination continuing	Return to disability	Age 65	Death	Continuing disability
Total	6, 194	100	44. 7	40. 9	3. 8	1. 1	2. 5	51. 7
Entitled spouse:								
Spouse	2, 643	100	50. 6	6. 6	4. 0	1. 0	2. 2	46. 2
No spouse	3, 551	100	40. 2	36. 5	3. 7	1. 2	2. 7	55. 9
Dependents: [3]								
None	2, 628	100	38. 6	35. 0	3. 6	2. 0	2. 3	57. 1
1	1, 011	100	44. 7	40. 2	4. 5	. 9	2. 3	52. 1
2	913	100	48. 3	44. 8	3. 5	. 5	3. 0	48. 2
3	685	100	52. 1	48. 9	3. 2	. 3	2. 8	44. 8
4	423	100	51. 3	47. 5	3. 8	. 5	1. 9	46. 3
5 or more	534	100	53. 5	48. 3	5. 2	----------	3. 2	43. 3

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[1] Based on vocational rehabilitation reports received during fiscal year 1969.

[2] Disabled person ceased to meet medical standards for disability, or engaged in substantial gainful activity.

[3] Entitled to social security benefits as dependent spouses or children of worker.

TABLE 56.—*Disabled-worker beneficiaries rehabilitated (with trust funds) in fiscal year 1969: recovery and other benefit termination experience, by trust fund status and benefit amount, December 1970* [1]

Primary insurance amount	Number	Percent distribution						
			Recovery terminations [2]					
		Total	Total	Termination continuing	Return to disability	Age 65	Death	Continuing disability
Total benefits:								
Under $80	313	100	31. 0	28. 1	2. 9	2. 6	2. 2	64. 2
$80 to $99	606	100	41. 1	37. 3	3. 8	1. 8	2. 0	55. 1
$100 to $149	1, 893	100	42. 2	38. 2	4. 0	1. 7	2. 5	53. 5
$150 to $199	1, 183	100	36. 2	31. 0	5. 2	. 6	2. 0	61. 2
$200 to $249	567	100	55. 2	51. 7	3. 5	. 5	2. 5	41. 8
$250 to $299	507	100	55. 5	52. 5	3. 0	. 4	3. 4	40. 8
$300 to $349	648	100	61. 2	58. 6	2. 6	. 6	2. 0	36. 1
$350 to $399	300	100	35. 0	31. 3	3. 7	. 3	2. 0	62. 7
$400 or more	72	100	22. 3	18. 1	4. 2	----------	16. 7	61. 1
Unknown	105	100	77. 1	75. 2	1. 9	1. 0	1. 9	20. 0

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[1] Based on vocational rehabilitation reports received from October 1967 through June 1968.

[2] Disabled person ceased to meet medical standards for disability, or engaged in substantial gainful activity.

TABLE 57.—*Disabled-worker beneficiaries rehabilitated (with trust funds) in fiscal 1969: recovery and other benefit termination experience as of December 1970, by 1970 earnings after rehabilitation*

Earnings after rehabilitation [1]	Percent distribution					
		Recovery terminations [2]				
	Total	Termination continuing	Return to disability	Age 65	Death	Continuing disability
Number	6, 194	2, 532	238	70	155	3, 199
Earnings in calendar 1969: Total percent	100. 0	100. 0	100. 0	100. 0	100. 0	100. 0
No earnings	44. 2	9. 3	70. 2	68. 6	98. 7	66. 7
$1 to $49	1. 8	. 9	5. 0	4. 3	0	2. 3
$50 to $999	8. 9	6. 1	16. 8	14. 3	0	10. 9
$1,000 to $1,999	7. 2	7. 5	5. 0	7. 1	0	7. 5
$2,000 to $2,999	5. 4	8. 5	2. 5	2. 9	0	3. 4
$3,000 to $3,999	5. 0	10. 0	0	1. 4	0	1. 8
$4,000 to $4,999	6. 0	12. 4	0	1. 4	. 6	1. 8
$5,000 to $5,999	5. 0	10. 3	0	0	. 6	1. 5
$6,000 to $6,999	5. 1	10. 4	0	0	0	1. 6
$7,000 to $7,799	3. 4	7. 3	0	0	0	. 9
$7,800 or more	7. 9	17. 4	. 4	0	0	1. 5

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[1] Earnings based on earnings taxable under social security, which are subject to maximum limits. No covered earnings since 1950 reported for 1 percent of the rehabilitants; some may have had noncovered earnings, others may have been incorrectly identified by account number.

[2] Recovery refers to OASDI benefit termination for medical improvement or return to sustained employment.

Staff question: ***Please give us total number of rehabilitants terminated from the disability rolls, 1960–66.***

After extensive search, we have been unable to locate the source material for years 1960–66 necessary to identify beneficiaries who were rehabilitated and the number of rehabilitants who were terminated from the rolls. No provision was made for accumulating and storing these data records prior to the inauguration of the beneficiary rehabilitation program.

C. Allocation of Trust Fund Resources for Rehabilitation

The total amount of funds that may be made available in a fiscal year for payment for the costs of vocational rehabilitation services may not exceed a specified percentage of the benefits certified for payment in the preceding year from the old-age and survivors insurance and disability insurance trust funds to disabled persons receiving benefits because of their disability. This limitation on the amounts to be made available was 1 percent in each fiscal year from 1966 (when such amounts first became available) through 1972 and 1¼ percent in fiscal year 1973. The following data show the relationship between the total amount of payments for the costs of such rehabilitation services for each fiscal year, 1966–73 and the corresponding amount of benefits paid in the prior fiscal year from the trust funds to disabled beneficiaries:

Table 58.—*Trust fund payments for costs of rehabilitation services as percentage of benefits paid to disabled persons, fiscal years 1966–73*

Fiscal year to which costs of rehabilitation services are charged	Amount of payments for costs of rehabilitation services [1] (thousands)	Estimated amount of benefit payments in preceding fiscal year to disabled beneficiaries (thousands)	Payments for costs of rehabilitation services as percent of preceding year's benefit payments
1966	$473	$1, 220, 340	0. 04
1967	9, 596	1, 483, 663	. 65
1968	15, 981	1, 600, 682	1. 00
1969	17, 517	1, 803, 657	. 97
1970	20, 622	2, 155, 579	. 96
1971	23, 102	2, 464, 004	. 94
1972	29, 914	3, 028, 695	. 99
1973	39, 756	3, 629, 590	1. 10

[1] The amounts shown represent the expenditures for a fiscal year and differ from amounts expended in a fiscal year as shown in accounting statements of the trust funds on a cash basis. The amounts shown for recent fiscal years are subject to further change.

Source.—Office of the Actuary, Mar. 26, 1974.

TABLE 59.—*Allocation of trust funds, by State, fiscal year 1973*

State or territory:	Total allocation[1]	State or territory:	Total allocation
Alabama	$1, 378, 294	Nebraska	$206, 141
Alaska	25, 911	Nevada	227, 200
Arizona	146, 681	New Hampshire	126, 541
Arkansas	907, 011	New Jersey	833, 376
California	3, 586, 423	New Mexico	412, 184
Colorado	368, 729	New York	3, 715, 511
Connecticut	408, 236	North Carolina	1, 306, 123
Delaware	114, 048	North Dakota	221, 855
District of Columbia	113, 240	Ohio	1, 689, 474
Florida	2, 335, 774	Oklahoma	475, 800
Georgia	1, 252, 033	Oregon	598, 312
Guam	4, 126	Pennsylvania	2, 262, 099
Hawaii	95, 033	Puerto Rico	250, 357
Idaho	329, 597	Rhode Island	159, 838
Illinois	1, 936, 369	South Carolina	886, 780
Indiana	663, 092	South Dakota	152, 502
Iowa	520, 215	Tennessee	1, 134, 777
Kansas	235, 843	Texas	2, 531, 034
Kentucky	812, 505	Utah	194, 177
Louisiana	467, 807	Vermont	146, 628
Maine	222, 931	Virginia	906, 992
Maryland	680, 586	Virgin Islands	14, 886
Massachusetts	842, 444	Washington	762, 013
Michigan	2, 111, 024	West Virginia	930, 540
Minnesota	789, 297	Wisconsin	752, 520
Mississippi	712, 140	Wyoming	59, 225
Missouri	764, 756		
Montana	153, 824	U.S. total	42, 934, 854

[1] Allocation to each State or territory as adjusted (increased/decreased) after June 30, 1973.

The total funds available for fiscal year 1973 were $45,369,875.

D. Social Security Beneficiaries Receiving Rehabilitation Services

1. NUMBER REHABILITATED AND SOURCE OF FUNDING OF SERVICES, 1966–73

Table 60.—*Social security disability insurance beneficiaries who are considered rehabilitated and still active and receiving State rehabilitation services, by source of funding indicated, fiscal years 1966–73*

Beneficiaries	Fiscal year—								Percent change, 1968 to 1973
	1973	1972	1971	1970	1969	1968	1967	1966	
Cases served:[1]									
Total	83, 877	77, 107	72, 137	64, 474	58, 437	50, 748			+65
With trust funds	52, 011	45, 110	40, 711	35, 275	32, 911	26, 455			+97
With regular VR funds	31, 866	31, 997	31, 426	29, 199	25, 526	24, 293			+31
Cases rehabilitated:									
Total	20, 868	19, 245	19, 029	17, 273	15, 998	12, 944	6, 852	6, 717	+61
With trust funds	11, 580	9, 983	9, 790	9, 307	8, 036	5, 934	1, 815		+95
With regular VR funds	9, 288	9, 262	9, 239	7, 966	7, 562	7, 010	5, 037	6, 717	+32
Active cases in process on hand June 30:									
Total	50, 524	46, 208	41, 773	37, 552	33, 547	30, 792	18, 751		+64
With trust funds	33, 225	28, 723	25, 068	20, 799	19, 911	17, 258	8, 649		+93
With regular VR funds	17, 299	17, 485	16, 705	16, 753	13, 636	13, 534	10, 102		+28

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[1] Cases served is the sum of the number of disability insurance beneficiaries in the active caseload on June 30, and those closed (i.e., no longer being provided rehabilitation services) rehabilitated and not rehabilitated from July 1 to June 30.

2. CRITERIA FOR SELECTING REHABILITATION PROGRAM—TRUST FUND OR REGULAR VOCATIONAL REHABILITATION

Staff question: ***What are the criteria used in determining whether Disability Insurance beneficiaries' rehabilitations will be financed out of Trust Fund moneys or regular VR appropriations? Who establishes these criteria? The Social Security Administration or the States?***

The criteria employed by State vocational rehabilitation agencies and agencies for the blind in selecting beneficiaries for rehabilitation services financed with trust fund moneys were established by the Social Security Administration and the Rehabilitation Services Administration (formerly the Vocational Rehabilitation Administration), in consultation with the Committee on Social Security Relationships of the Council of State Administrators of Vocational Rehabilitation. The selection criteria are aimed at selecting individuals whose rehabilitation potential and employment objectives are at levels wherein the attainment of the objective is likely to result in the beneficiary being taken off the social security rolls and effecting a saving, or at least no net cost to the trust funds.

The criteria are:

1. There is present a disabling physical or mental impairment which is not so rapidly progressive as to outrun the effect of vocational rehabilitation services, or to preclude restoration of the beneficiary to productive activity.
2. The disabling effect of the impairment, without the services planned, is expected to remain at a level of severity which would result in the continuing payment of disability benefits.
3. There is a reasonable expectation that the provision of such services will result in the restoration of the individual to productive activity.[1]
4. The reasonably predictable period of productive work activity is of sufficient duration that benefits to be saved and the contributions which would be paid to the trust funds on future earnings would offset the costs of the services planned.

The above criteria are incorporated in 45 C.F.R. 401.110–118.

3. VOCATIONAL REHABILITATION (TRUST FUND AND REGULAR) CASES CLOSED AND NUMBER OF REHABILITATIONS

It should be noted that the following table gives only case closings and rehabilitations and does not give terminations from the benefit roll. The latter are given on pages 286–290.

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[1] Productive activity is defined as full-time or substantial part-time employment or self-employment wherein the nature of the work activity performed, the earnings received, or both, or the capacity to engage in such employment or self-employment can reasonably be expected to result in termination or nonpayment of social security disability benefits.

Table 61.—*Cumulative total of beneficiary cases closed from State rehabilitation agency rolls, fiscal years 1967–73, and number and percent successfully rehabilitated, by State*

State or territory	Number disability beneficiary cases closed [1]	Successfully rehabilitated	Percent of total
Total	457, 181	112, 433	24. 6
Alabama	9, 043	2, 734	30. 2
Alaska	440	143	32. 5
Arizona	2, 451	506	20. 6
Arkansas	6, 533	1, 614	24. 7
California	56, 937	7, 184	12. 6
Colorado	3, 296	1, 217	36. 9
Connecticut	2, 739	821	30. 0
Delaware	749	418	55. 8
District of Columbia	992	320	32. 3
Florida	28, 004	4, 449	15. 9
Georgia	14, 826	3, 609	24. 3
Guam	36	16	44. 4
Hawaii	2, 419	678	28. 0
Idaho	1, 006	374	37. 2
Illinois	8, 028	4, 366	54. 4
Indiana	3, 958	1, 291	32. 6
Iowa	6, 255	2, 007	32. 1
Kansas	3, 600	876	24. 3
Kentucky	7, 746	2, 301	29. 7
Louisiana	4, 883	1, 307	26. 8
Maine	1, 291	307	23. 8
Maryland	6, 686	2, 880	43. 1
Massachusetts	4, 462	1, 256	28. 1
Michigan	11, 772	3, 137	26. 6
Minnesota	9, 487	2, 273	24. 0
Mississippi	14, 593	2, 476	17. 0
Missouri	9, 327	2, 920	31. 3
Montana	2, 347	541	23. 1
Nebraska	1, 837	746	40. 6
Nevada	1, 247	318	25. 5
New Hampshire	1, 199	336	28. 0
New Jersey	9, 445	2, 158	22. 8
New Mexico	2, 678	596	22. 3
New York	34, 333	8, 895	25. 9
North Carolina	13, 526	3, 553	26. 3
North Dakota	1, 894	577	30. 5
Ohio	17, 937	4, 342	24. 2
Oklahoma	4, 523	1, 868	41. 3
Oregon	4, 224	1, 195	28. 3
Pennsylvania	38, 760	8, 065	20. 8
Puerto Rico	1, 619	622	38. 4
Rhode Island	2, 505	1, 190	47. 5
South Carolina	9, 183	2, 101	22. 9
South Dakota	1, 169	414	35. 4
Tennessee	8, 410	1, 776	21. 1
Texas	29, 002	7, 257	25. 0
Utah	1, 902	405	21. 3
Vermont	1, 317	307	23. 3
Virginia	7, 938	2, 128	26. 7
Virgin Islands	71	9	12. 7
Washington	6, 041	1, 284	21. 3
West Virginia	8, 729	2, 005	23. 0
Wisconsin	23, 069	8, 063	35. 0
Wyoming	717	202	28. 2

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[1] Includes rehabilitated (status 26); not rehabilitated (status 28–30); and, not accepted for vocational rehabilitation (status 08).

4. PRELIMINARY REPORT: RECOVERY AND RECIDIVISM EXPERIENCE IN JUNE 1973 OF DISABILITY BENEFICIARIES REHABILITATED UNDER THE TRUST FUND REIMBURSEMENT PROGRAM, 1967–72

From the beginning of the trust fund reimbursement program following the 1965 amendments to the Social Security Act through June 1973, the State vocational rehabilitation agencies have reported over 55,000 beneficiaries rehabilitated with the use of trust funds.[2] This report describes the demographic and benefit characteristics of 30,000 of these disability beneficiaries who were reported rehabilitated and returned to work from 1967 through the end of calendar year 1972. Their recent social security benefit status and earnings experience is examined, with special focus on what characteristics distinguish those who leave the social security benefit rolls after rehabilitation from those who do not, and what factors distinguish those who retain working capacity from persons who return to the disability benefit rolls after rehabilitation and benefit termination.

Previous reports have described the initial development of the trust fund program, estimated lifetime savings through benefit termination of disabled beneficiaries, and examined demographic earnings, and benefit characteristics of trust fund rehabilitants in fiscal years 1968 and 1969, and compared their characteristics to those of rehabilitated beneficiaries not in the trust fund program.[3]

The study population described in this report includes many of those rehabilitated in fiscal years 1968 and 1969 and adds beneficiaries rehabilitated in fiscal year 1970–72 and some rehabilitated in the first part of fiscal year 1973. Not included in this population are those rehabilitated under the trust fund program before fiscal year 1967 or after December 1972; those who were not reported as returned to work upon rehabilitation closure by the vocational rehabilitation agencies; and those whose closure reports were not matched by account number to social security records or whose disability benefit status had not been verified.[4]

The study population of 30,888 beneficiaries reported rehabilitated through 1972 in the trust fund program consists largely of 28,058 disabled worker beneficiaries (table 1). An additional 2,804 were dependent adults (Disabled Adult Children) who had been disabled since age 18. The remaining 26 rehabilitated in the trust fund program were disabled widow beneficiaries, who have to be age 50 or over to receive benefits.

Recovery Experience

In this report and table attachment, recovery refers to beneficiaries who leave the social security rolls for medical recovery or return to work. "Active recoveries" or those "currently off rolls" refers to those recovered beneficiaries who have left the social security rolls, and neither attained age 65 nor been reported deceased—this is the group for whom benefit savings are assumed due to the financing of services as long as they retain working capacity and stay off the rolls. Of the total of 30,888 rehabilitants, 38.9 percent were currently off the rolls as active recoveries in June 1973 (table 62).

These were almost all disabled workers. A much smaller proportion of disabled adult children than disabled workers who were rehabilitated, left the benefit rolls—only 20 percent of the disabled adult children to about 40 percent of disabled workers. A little over 7 percent of rehabilitated disabled worker beneficiaries were terminated for recovery, but then returned to the rolls by June 1973—this is the group described as "recidivists." No disabled dependent adults who left the rolls were reentitled. (Some recidivists who may have returned to the rolls after recovery termination, but then *again* went off the rolls for recovery and were off the rolls in June 1973 are included in the classification of the data as active recoveries, as of June 1973.)

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[2] See "Quarterly Status Report of Social Security Disability Insurance Beneficiaries," Rehabilitation Services Administration, January 10, 1974, and previous reports in this series; and Report to Senate Finance Committee, Social Security Administration, January 1972.

[3] Report to the Senate Finance Committee, op. cit.; "Recovery of Disabled After Trust Fund Financing of Rehabilitation," *Social Security Bulletin*, February 1973.

[4] Verification refers to a procedure whereby the State VR agencies ask the Social Security Administration for confirmation that a potential trust fund client is on the social security rolls as a disabled beneficiary. A control file of these cases is set up and is used for notices to VR agencies upon benefit termination so that trust fund money will not go for further services. In the past, cases not matched with this verification file were not added to the statistical file of rehabilitated trust fund cases.

Of the remaining rehabilitants, about 4 percent were deceased as of June 1973 and about 40 percent remained on the disability benefit rolls. Some may have been in the process of benefit termination as of June 1973, including some receiving benefits for a limited period under the trial work provisions, but most of these may be presumed not to have been restored to sustained earnings capacity after rehabilitation closure.

Demographic Factors

Factors affecting the proportion of rehabilitants among the disabled worker beneficiaries who go on to leave the social security rolls include sex, age, family status, and prior earnings (table 2). In comparison to a little over 40 percent of the entire group in active recovery status in June 1973, a smaller proportion of women (34 percent) and a much higher proportion of younger workers (64 percent of those under age 45) left the social security benefit rolls and were off the rolls in June 1973. A greater proportion of workers with several dependents left the beneficiary rolls. This may also reflect the younger age of persons with several children under 18.

The level of economic status prior to disability is indicated by differences in the Primary Insurance Benefit Amount (PIA). Higher earners had a substantially greater proportion who left the benefit rolls after services than lower earners. Over 50 percent of those with a PIA of $200 or more left the rolls for recovery compared to about 30 percent of those with a PIA under $100. The differences in health indicated by death after closure was not very different at all by income group based on PIA. It may be likely that persons with higher earnings before disability returned to better employment situations after services than lower earners.

A smaller proportion of older rehabilitants are shown as recidivists. Some with recurring work difficulties may become early retirees rather than seek to establish a new disability. There is almost no difference in the rate of recidivism by dependent family status or sex. A somewhat greater proportion of higher earners, as indicated by PIA, are reentitled (about 8 percent of these with a PIA over $150 compared to 3 percent of those with a PIA under $100). Almost all of the rehabilitated men who had been disabled and dependent since age 18 or earlier were under age 45.

A much smaller proportion of the older disabled adult children left the rolls than those under age 45 (less than 8 percent compared to about 20 percent of those under age 45).

Earnings After Rehabilitation

Of all these disabled workers rehabilitated from 1967 through 1972, over half had earnings in covered employment in 1972 and over one-fifth had earnings of $5,000 or more (table 2). Of those who were not only rehabilitated, but left the social security rolls for medical recovery or return to substantial gainful employment and were neither age 65 or dead in 1973, over 85 percent had some earnings in 1972 and nearly 50 percent had earnings of $5,000 or more.

The earlier the year of rehabilitation closure, the less likely the rehabilitants had earnings in 1972 (table 4). About 10 percent of those rehabilitated in fiscal year 1972 had no reported earnings in 1972 compared to nearly 20 percent of those rehabilitated in fiscal year 1968, among the active recovery cases. There was little difference among the proportion of higher earners by year of closure. About a quarter of all rehabilitants and one-half of all active recoveries had earnings of $5,000 or more.

Benefit Savings

The median family benefit at termination for those 11,472 disabled workers who left the rolls after rehabilitation and remained in active recovery status as of June 1973 was over $250. Nearly three-quarters had been receiving family benefits of $200 or more at the time of benefit termination for recovery.

In this report "benefit savings" refers to disability benefits not paid after recovery termination following rehabilitation for those persons who had been disabled beneficiaries and are under age 65 and not early retirees or deceased. The accumulated savings through June 1973 was $10,000 or more for 5,405 workers or nearly 20 percent of the 28,000 disabled worker rehabilitants in this study. For nearly half, the accumulated savings was over $1,000. For the active group who remained currently off the rolls in June 1973, over 40 percent (5,006) had $10,000 or more in benefits no longer received. For half of the entire group of rehabilitated disabled workers, no benefit savings resulted as of June 1973.

For nearly 40 percent of the recidivists (808 workers), accumulated savings amounted to over $5,000 for each family in spite of the fact the workers were back on the rolls as of June 1973.

Conclusion

About 4 out of 10 of this group of disabled workers rehabilitated under the trust fund program and returned to work left the disability benefit rolls. A substantially smaller proportion of dependent children disabled since age 18 left the rolls.

As noted in previous reports, younger age, male sex, and higher predisability earnings led to a greater likelihood of recovery termination. A substantial proportion of disabled workers continue working after rehabilitation, Of those who left the social security rolls after rehabilitation closure in 1967–72. almost all had earnings in 1972 and nearly half had earnings of $5,000 or more.

About 8 percent of the rehabilitants had returned to the disability benefit rolls after recovery by June 1973. This is the group described as recidivists. There was little difference by sex or family status in the rate of recidivism, but older workers and lower earners had a somewhat lower rate. This may reflect differences in opportunities for those who were able to return to sustained and substantial work initially by these characteristics and possibly the availability of early retirement benefits for partly disabled older workers.

Of all the 28,000 disabled worker rehabilitants, the accumulated savings through June 1973 was over $1,000 for nearly half and over $10,000 for nearly 20 percent.

TABLE 62.—*Trust fund rehabilitants, 1967–72: Benefit status in June 1973, by type of beneficiary*

Social security benefit status	Total[1]	Type of beneficiary	
		Disabled worker	Disabled adult, children
Number of rehabilitated beneficiaries	30, 888	28, 058	2, 804
Active recovery[2]	12, 007	11, 472	533
Recidivist[3]	2, 112	2, 111	0
Dead	1, 311	1, 264	47
Under age 65 and not terminated	13, 151	11, 486	1, 649
All others	2, 307	1, 725	575
Total percent down	100. 0	100. 0	100. 0
Active recovery	38. 9	40. 9	19. 0
Recidivist	6. 8	7. 5	0
Dead	4. 2	4. 5	1. 7
Under age 65 and not terminated	42. 6	40. 9	58. 8
All others	7. 5	6. 1	20. 5

[1] Based on VR agency closure reports matched to social security benefit records. Not included are persons reported as trust fund rehabilitants not engaged at work for earnings at closure or not verified as disability beneficiaries. The total includes 26 disabled widow beneficiaries.

[2] Terminated for medical recovery or return to work and neither age 65 nor deceased.

[3] On disability rolls as of June 1973 after previous benefit termination.

TABLE 63.—*Disabled worker beneficiaries rehabilitated under the trust fund reimburs[illegible]gram, 1967–72: demographic characteristics, earnings experience, and benefit status as of June 1973*

Workers only	Type of case																	
	All cases			Recidivists [1]			Currently off rolls [2]			Dead			No termination			All others		
	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column
Total	28,058	100	100.0	2,111	7.5	100.0	11,472	40.9	100.0	1,264	4.5	100.0	11,486	40.9	100.0	1,725	6.1	100.0
Sex:																		
Male	23,337	100	83.2	1,740	7.5	82.4	9,869	42.3	86.0	1,085	4.6	85.8	9,200	39.4	80.1	1,443	6.2	83.7
Female	4,721	100	16.8	371	7.9	17.6	1,603	34.0	14.0	179	3.8	14.2	2,286	48.4	19.9	282	6.0	16.3
Age in year of closure:																		
Under 45	14,036	100	50.0	1,047	7.5	49.6	7,336	52.3	63.9	315	2.2	24.9	4,879	34.8	42.5	459	3.3	26.6
45 to 49	4,341	100	15.5	368	8.5	17.4	1,749	40.3	15.2	194	4.5	15.3	1,909	44.0	16.6	121	2.8	7.0
50 to 54	4,055	100	14.5	371	9.1	17.6	1,298	32.0	11.3	250	6.2	19.8	2,053	50.6	17.9	83	2.0	4.8
55 to 59	3,496	100	12.5	261	7.5	12.4	833	23.8	7.3	331	9.5	26.2	1,918	54.9	16.7	153	4.4	8.9
60 to 64	1,707	100	6.1	41	2.4	1.9	134	7.9	1.2	160	9.4	12.7	604	35.4	5.3	768	45.0	44.5
65 and up	125	100	.4	0	0	0	0	0	0	1	.8	.1	0	0	0	124	99.2	7.2
Unknown	298	100	1.1	23	7.7	1.1	122	40.9	1.1	13	4.4	1.0	123	41.3	1.1	17	5.7	1.0
Months off rolls:																		
None	11,740	100	41.8	0	0	0	0	0	0	33	.3	2.6	11,486	97.8	100.0	221	1.9	12.8
1 to 6	1,564	100	5.6	560	35.8	26.5	686	43.9	6.0	210	13.4	16.6	0	0	0	108	6.9	6.3
7 to 12	1,913	100	6.8	412	21.5	19.5	1,188	62.1	10.4	195	10.2	15.4	0	0	0	118	6.2	6.8
13 to 24	3,583	100	12.8	555	15.5	26.3	2,430	67.8	21.2	369	10.3	29.2	0	0	0	229	6.4	13.3
25 to 36	3,085	100	11.0	339	11.0	16.1	2,240	72.6	19.5	303	9.8	24.0	0	0	0	203	6.6	11.8
31 to 48	2,796	100	10.0	165	5.9	7.8	2,402	85.9	20.9	117	4.2	9.3	0	0	0	112	4.0	6.5
49 and up	3,377	100	12.0	80	2.4	3.8	2,526	74.8	22.0	37	1.1	2.9	0	0	0	734	21.7	42.6
Auxiliary beneficiaries:																		
None	11,682	100	41.6	871	7.5	41.3	4,189	35.9	36.5	634	5.4	50.2	5,029	43.0	43.8	959	8.2	55.6
1	1,976	100	7.0	162	8.2	7.7	672	34.0	5.9	100	5.1	7.9	871	44.1	7.6	171	8.7	9.9
2	3,610	100	12.9	272	7.5	12.9	1,584	43.9	13.8	160	4.4	12.7	1,394	38.6	12.1	200	5.5	11.6
3	3,872	100	13.8	267	6.9	12.6	1,864	48.1	16.2	140	3.6	11.1	1,443	37.3	12.6	158	4.1	9.2
4 and up	6,918	100	24.7	539	7.8	25.5	3,163	45.7	27.6	230	3.3	18.2	2,749	39.7	23.9	237	3.4	13.7
Entitled spouse:																		
Yes	12,551	100	44.8	945	7.5	44.8	5,663	45.0	49.4	465	3.7	36.8	4,888	38.9	42.6	620	4.9	35.9
No	15,477	100	55.2	1,166	7.5	55.2	5,809	37.5	50.6	799	5.2	63.2	6,598	42.6	57.4	1,105	7.1	64.1
Family benefits at termination:																		
$1 to $99	782	100	2.8	20	2.6	.9	205	26.2	1.8	33	4.2	2.6	477	61.0	4.2	47	6.0	2.7
$100 to $149	3,542	100	12.6	195	5.5	9.2	1,130	31.9	9.9	187	5.3	14.8	1,792	50.6	15.6	238	6.7	13.9
$150 to $199	4,899	100	17.5	378	7.7	17.9	1,785	36.4	15.6	279	5.7	22.1	2,173	44.4	18.9	284	5.8	16.5
$200 to $249	5,402	100	19.3	454	8.4	21.5	2,302	42.6	20.1	284	5.3	22.5	2,059	38.1	17.9	303	5.6	17.6
$250 to $299	2,044	100	7.3	176	8.6	8.3	973	47.6	8.5	78	3.8	6.2	761	37.2	6.6	56	2.7	3.2
$300 and up	10,521	100	37.5	829	7.9	39.3	5,034	47.8	43.9	401	3.8	31.7	4,092	38.9	35.6	165	1.6	9.6
Unknown	868	100	3.1	59	6.8	2.8	43	5.0	.4	2	.2	.2	132	15.2	1.1	632	72.8	36.6
Primary insurance amount at termination:																		
$1 to $74	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
$75 to $99	1,182	100	4.2	36	3.0	1.7	317	26.8	2.8	46	3.9	3.6	717	60.7	6.2	66	5.6	3.8
$100 to $149	5,428	100	19.3	303	5.6	14.4	1,836	33.8	16.0	279	5.1	22.1	2,703	49.8	23.5	307	5.7	17.8
$150 to $199	8,432	100	30.1	722	8.6	34.2	3,331	39.5	29.0	410	4.9	32.4	3,631	43.1	31.6	338	4.0	19.6
$200 and up	12,385	100	44.1	1,050	8.5	49.7	5,988	48.3	52.2	529	4.3	41.9	4,435	35.8	38.5	383	3.1	22.2
Unknown	631	100	2.2	0	0	0	0	0	0	0	0	0	0	0	0	631	100.0	36.6

See footnotes at end of table.

TABLE 63.—*Disabled worker beneficiaries rehabilitated under the trust fund reimbursement program, 1967–72: demographic characteristics, earnings experience, and benefit status as of June 1973*—Continued

Workers only	Type of case																	
	All cases			Recidivists [1]			Currently off rolls [2]			Dead			No termination			All others		
	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column
Earnings, 1972																		
0 to $	12,593	100	44.9	1,054	8.4	49.9	1,520	12.1	13.2	1,141	9.1	90.3	8,041	63.9	70.0	837	6.6	48.5
$1 to 999	2,856	100	10.2	329	11.5	15.6	614	21.5	5.4	63	2.2	5.0	1,717	60.1	14.9	133	4.7	7.7
$1,000 to $2,999	3,482	100	12.4	359	10.3	17.0	1,588	45.6	13.8	36	1.0	2.8	1,294	37.2	11.3	205	5.9	11.9
$3,000 to $4,999	2,828	100	10.1	181	6.4	8.6	2,236	79.1	19.5	11	.4	.9	257	9.1	2.2	143	5.1	8.3
$5,000 and up	6,299	100	22.4	188	3.0	8.9	5,514	87.5	48.1	13	.2	1.0	177	2.8	1.5	407	6.5	23.6
Earnings, 1971:																		
0 to $	13,110	100	46.7	786	6.0	37.2	2,447	18.7	21.3	994	7.6	78.6	8,034	61.3	69.9	849	6.5	49.2
$1 to $999	3,815	100	13.6	349	9.1	15.5	1,080	28.3	9.4	147	3.9	11.6	2,078	54.5	18.1	161	4.2	9.3
$1,000 to $2,999	3,752	100	13.4	415	11.1	19.7	1,959	52.2	17.1	73	1.9	5.8	1,122	29.9	9.8	183	4.9	10.6
$3,000 to $4,999	2,665	100	9.5	270	10.1	12.8	2,056	77.1	17.9	25	.9	2.0	167	6.3	1.5	147	5.5	8.5
$5,000 and up	4,716	100	16.8	291	6.2	13.8	3,930	83.3	34.3	25	.5	2.0	85	1.8	.7	385	8.2	22.3
Earnings, 1970:																		
0 to $	14,470	100	51.6	620	4.3	29.4	4,001	27.7	34.9	869	6.0	68.8	8,179	56.5	71.2	801	5.5	46.4
$1 to $999	3,840	100	13.7	344	9.0	16.3	1,126	29.3	9.8	207	5.4	16.4	1,985	51.7	17.3	178	4.6	10.3
$1,000 to $2,999	3,704	100	13.2	447	12.1	21.2	1,829	49.3	15.9	121	3.3	9.6	1,109	29.9	9.7	198	5.3	11.5
$3,000 to $4,999	2,494	100	8.9	334	13.4	15.8	1,803	72.3	15.7	42	1.7	3.3	134	5.4	1.2	181	7.3	10.5
$5,000 and up	3,550	100	12.7	366	10.3	17.3	2,713	76.4	23.6	25	.7	2.0	79	2.2	.7	367	10.3	21.3
Number of years over $2,999 (1966–72) [3]:																		
None	15,815	100	56.4	762	4.8	36.1	2,454	15.5	21.4	1,082	6.8	85.6	10,566	66.8	92.0	951	6.0	55.1
1	4,128	100	14.7	535	13.0	25.3	2,671	64.7	23.3	104	2.5	8.2	686	16.6	6.0	132	3.2	7.7
2	2,819	100	10.0	372	13.2	17.6	2,170	77.0	18.9	51	1.8	4.0	139	4.9	1.2	87	3.1	5.0
3	2,246	100	8.0	242	10.8	11.5	1,840	81.4	16.0	15	.7	1.2	49	2.2	.4	100	4.5	5.8
4	1,756	100	6.3	135	7.7	6.4	1,494	85.1	13.0	9	.5	.7	26	1.5	.2	92	5.2	5.3
5	957	100	3.4	46	4.8	2.2	743	77.6	6.5	3	.3	.2	12	1.3	.1	153	16.0	8.9
6	293	100	1.0	16	5.5	.8	94	32.1	.8	0	0	0	8	2.7	.1	175	59.7	10.1
7	44	100	.2	3	6.8	.1	6	13.6	.1	0	0	0	0	0	0	35	79.5	2.0
Accumulated savings: [4]																		
0	14,137	100	50.4	0	0	0	0	0	0	1,107	7.8	87.6	11,486	81.2	100.0	1,544	10.9	89.5
$1 to $999	797	100	2.8	363	45.5	17.2	359	45.0	3.1	32	4.0	2.5	0	0	0	43	5.4	2.5
$1,000 to $4,999	3,815	100	13.6	930	24.4	44.1	2,754	72.2	24.0	74	1.9	5.9	0	0	0	57	1.5	3.3
$5,000 to $9,999	3,904	100	13.9	464	11.9	22.0	3,353	85.9	29.2	32	.8	2.5	0	0	0	55	1.4	3.2
$10,000 and up	5,405	100	19.3	354	6.5	16.8	5,006	92.6	43.6	19	.4	1.5	0	0	0	26	.5	1.5
Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Year of recovery termination:																		
Never	13,346	100	47.6	2,063	15.5	97.7	14	.1	.1	0	0	0	11,183	83.8	97.4	86	.6	5.0
Pre-1966	6	100	0	0	0	0	1	16.7	0	3	50.0	.2	0	0	0	2	33.3	.1
1966	54	100	.2	0	0	0	1	1.9	0	0	0	0	0	0	0	53	98.1	3.1
1967	556	100	2.0	0	0	0	87	15.6	.8	0	0	0	0	0	0	469	84.4	27.2
1968	1,610	100	5.7	0	0	0	1,435	89.1	12.5	2	.1	.2	1	.1	0	172	10.7	10.0
1969	2,330	100	8.3	0	0	0	2,232	95.3	19.5	22	.9	1.7	1	0	0	75	3.2	4.3
1970	2,827	100	10.1	1	0	0	2,418	85.5	21.1	227	8.0	18.0	3	.1	0	178	6.3	10.3
1971	2,812	100	10.0	6	.2	.3	2,225	79.1	19.4	354	12.6	28.0	9	.3	.1	218	7.8	12.6
1972	3,127	100	11.1	6	.2	.3	2,444	78.2	21.3	431	13.8	34.1	12	.4	.1	234	7.5	13.6
1973	1,390	100	5.0	35	2.5	1.7	615	44.2	5.4	225	16.2	17.8	277	19.9	2.4	238	17.1	13.8

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[1] On disability rolls as of June 1973 after prior benefit termination.

[2] Disability benefit termination for recovery or work and under age 65.

[3] Number of years of earnings of $3,000 or more between 1966–72.

[4] Benefit savings due to recovery termination.

TABLE 64.—*Disabled dependent adults rehabilitated under the trust fund reimbursement program, 1967–72: demographic characteristics, earnings experience, and benefit status as of June 1973—disabled adult children only*

	All cases			Recidivists [1]			Currently off roles [2]			Dead			No termination			All others		
	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column	Frequency	Percent of row	Percent of column
Total	2,804	100	100	0	0	100	533	19	100	47	1.7	100	1,649	58.8	100	575	20.5	100
Sex:																		
Male	2,804	100	100	0	0	0	533	19	100	47	1.7	100	1,649	58.8	100	575	20.5	100
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Age in year of closure:																		
Under 45	2,447	100	87.3	0	0	0	512	20.9	96.1	38	1.6	80.9	1,348	55.1	81.7	549	22.4	95.5
45 to 49	120	100	4.3	0	0	0	9	7.5	1.7	4	3.3	8.5	98	81.7	5.9	9	7.5	1.6
50 to 54	87	100	3.1	0	0	0	4	4.6	.8	1	1.1	2.1	80	92.0	4.9	2	2.3	.3
55 to 59	80	100	2.9	0	0	0	1	1.3	.2	2	2.5	4.3	73	91.3	4.4	4	5.0	.7
60 to 64	39	100	1.4	0	0	0	0	0	0	1	2.6	2.1	31	79.5	1.9	7	17.9	1.2
65 and up	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	31	100	1.1	0	0	0	7	22.6	1.3	1	3.2	2.1	19	61.3	1.2	4	12.9	.7
Months off roles:																		
None	1,653	100	59.0	0	0	0	0	0	0	0	0	0	1,647	99.6	99.9	6	.4	1.0
1 to 6	62	100	2.2	0	0	0	11	17.7	2.1	10	16.1	21.3	1	1.6	.1	40	64.5	7.0
7 to 12	70	100	2.5	0	0	0	31	44.3	5.8	4	5.7	8.5	0	0	0	35	50.0	6.1
13 to 24	199	100	7.1	0	0	0	84	42.2	15.8	9	4.5	19.1	0	0	0	106	53.3	18.4
25 to 36	225	100	8.0	0	0	0	113	50.2	21.2	10	4.4	21.3	1	.4	.1	101	44.9	17.6
37 to 48	214	100	7.6	0	0	0	116	54.2	21.8	6	2.8	12.8	0	0	0	92	43.0	16.0
49 and up	381	100	13.6	0	0	0	178	46.7	33.4	8	2.1	17.0	0	0	0	195	51.2	33.9

[1] On disability rolls as of June 1973 after previous benefit termination.

[2] Disability benefit termination for medical recovery or return to work and under 65 years of age.

TABLE 65.—*Earnings in 1972 of disabled worker beneficiaries rehabilitated under trust fund reimbursement program, by year of rehabilitation closure and benefit savings status, June 1973*

Year of rehabilitation closure (fiscal year)	Number of rehabilitants				Percent with no earnings in 1972				Percent with earnings of $5,000 or more in 1972			
	Total [1]	Active recovery [2]	Recidivist [3]	Active, no termination	Total	Active recovery	Recidivist [3]	Active, no termination	Total	Active recovery	Recidivist [3]	Active, no termination
Total	28, 058	11, 472	2, 111	11, 486	44. 9	13. 2	49. 9	70. 0	22. 4	48. 1	8. 9	1. 5
1968	3, 732	1, 240	399	1, 391	56. 3	18. 5	66. 4	82. 2	20. 6	50. 6	4. 0	. 6
1969	4, 362	2, 085	488	1, 356	45. 0	14. 6	59. 2	77. 4	27. 1	52. 6	7. 4	. 5
1970	4. 848	2. 305	424	1, 704	43. 5	12. 6	49. 8	74. 4	25. 6	50. 3	9. 4	1. 3
1971	4, 435	2, 037	268	1. 845	40. 7	11. 9	29. 5	68. 5	25. 3	51. 9	11. 6	1. 2
1972	6, 249	2, 480	255	3, 225	40. 2	9. 7	24. 7	62. 4	21. 4	48. 2	17. 6	2. 6
1973 [4]	2, 158	978	67	992	32. 8	15. 8	22. 4	50. 4	12. 5	23. 2	10. 4	2. 5
Other, including unknown and 1967 closures	2, 274	347	210	973	61. 6	17. 0	62. 9	82. 7	11. 9	65. 4	3. 3	2. 6

[1] All others, including deaths and retired, included in totals only.

[2] Benefit termination for recovery and under 65 and not deceased.

[3] Benefit termination but reentitled for disability benefits as of June 1973

[4] 1st half of fiscal year 1973 only.

E. VOCATIONAL REHABILITATION AND THE SUPPLEMENTAL SECURITY INCOME PROGRAM

Staff question: ***What is being done in carrying out the provision which requires referral of blind and disabled SSI beneficiaries, and how will this compare with vocational rehabilitation under the old law?***

The Secretary has adopted the position that not only persons who are allowed SSI disability/blindness payments, but also those who are denied will be referred to State vocational rehabilitation agencies or agencies for the blind for possible services. Therefore, social security procedures specify that when an individual applies for SSI disability/blindness payments he will be furnished with a leaflet about vocational rehabilitation and a vocational rehabilitation application blank so that he may, if he wishes, contact the vocational rehabilitation agency and request services. Then, when his claim is sent to the State disability determination unit (DDU), which is usually a component of a State vocational rehabilitation agency, the disability determination unit will have the dual responsibility of deciding whether he meets the supplemental security income disability/blindness requirements and evaluating his potential for vocational rehabilitation. If the individual has rehabilitation potential, he will be referred to the appropriate State vocational rehabilitation agency. In all such cases, the disability determination unit will share with the vocational rehabilitation counselor any medical, vocational, or other information which may be helpful in the rehabilitation process. If the individual is too young to be served by the vocational rehabilitation agency, the disability determination unit may recall his file upon attainment of an appropriate age for assessment of rehabilitation potential. The Social Security Administration disability office, in taking the claim, is charged with the responsibility for making whatever referrals to social and health agencies or other agencies which may assist the child. Present procedures call for the reassessment of the rehabilitation potential of a disability/blindness benefit recipient each time his file is returned to the disability determination unit for a continuing eligibility determination.

In contrast to the above, State welfare agencies were not required to refer blind (AB) and disabled (APTD) recipients for vocational rehabilitation. However, in the agencies' desire to assist the handicapped practically all blind recipients as well as some disabled recipients were referred for community services and rehabilitation.

In conclusion, it seems reasonable to state that supplemental security income disabled applicants, whether allowed or denied, will have a greater likelihood of being served and rehabilitated than did their counterparts under the old program.

F. HEW STUDY OF EXPERIENCE IN FINANCING THE VOCATIONAL REHABILITATION OF DISABILITY BENEFICIARIES FROM THE SOCIAL SECURITY TRUST FUND—COST BENEFIT STUDY

Staff question: ***Prepare an update of the cost-benefit analysis of the Trust Fund rehabilitation program which was prepared for the Committee on Finance in 1972.***

Benefit-Cost Calculations for Vocational Rehabilitation With Trust Fund Moneys

According to our updated calculations covering the experience of the Beneficiary Rehabilitation Program through fiscal year 1973, there will be "savings of about $2.50 to the social security system for every $1 spent in the rehabilitation of disabled beneficiaries." Although this is a relatively high benefit-cost ratio, I believe that recent experience indicates that we should be attentive to future developments in the program.

Even though we encountered difficulties in securing all the data needed for our calculations, it was decided to conduct a preliminary analysis rather than to wait until the data are more complete. The values in the attached table are, therefore, based on detailed information on 12,991 terminations of benefits as compared to an overall count of 14,455.

The procedures and assumptions used in the calculations are similar to those used in previous calculations of the benefit-cost ratios of the program. Only three changes have been made. We are now basing the expected "savings" on more recent experience in the rates of terminations for disabled-worker benefits, which were also used in the cost estimates for the 1973 and 1974 reports of the Board of Trustees. Secondly, the calculations have been simplified by using only ultimate termination rates. This simplification will only have a minor effect on the "savings". Finally, we are now assuming that benefits will increase at 3% per year according to the automatic adjustment provisions.

TABLE 66.—*Benefit-cost computation for the vocational rehabilitation program—preliminary data*

Fiscal year	Cases terminated		Present value of expenditures[1] (in millions)		Present value of savings[2] (in millions)		Ratio of savings to expenditures	
	In year	Cumulative through year	In year	Cumulative through year	In year	Cumulative through year	In year	Cumulative through year
1966			0.5	0.5				
1967	183	183	9.5	10.0	4.1	4.1	0.43	0.41
1968	1,069	1,252	14.7	24.7	25.5	29.6	1.73	1.20
1969	2,105	3,357	15.2	39.9	57.7	87.3	3.80	2.19
1970	2,549	5,906	17.1	57.0	63.6	150.9	3.72	2.65
1971	2,365	8,271	18.8	75.8	56.9	207.8	3.03	2.74
1972	2,559	10,830	22.0	97.8	60.4	268.2	2.75	2.74
1973	2,161	12,991	29.4	127.2	48.4	316.6	1.65	2.49

[1] The present value of the expenditures represents the amount of money which would have had to be in the trust fund on July 1, 1966, in order to pay for the expenses incurred in the year regarding rehabilitation of disabled beneficiaries if the trust fund interest accrues at 6 percent per year.

[2] The present value of the savings represents the additional amount of money which would have had to be in the trust fund on July 1, 1966, in order to pay the additional benefits if the disabled beneficiaries had remained on the beneficiaries rolls and if interest accrues at 6 percent per year.

It may be noted from the table (next-to-last column) that the annual benefit-cost ratio has been decreasing for the last four fiscal years (from 3.80 in FY 1969 to 1.65 in FY 1973), and that the cumulative experience (last column) is starting to show a decrease. The benefit-cost ratio of 2.74 for the overall period FY 1966–72 decreased to 2.49 for the overall period FY 1966–73.

These ratio are still over 1.0—that is, the expected benefits are larger than the cost, and indicate that the program is still financially justifiable. However, the recent experience suggests that further growth in the program should not be contemplated until there is a better understanding of what has caused the recent declines.

FRANCISCO BAYO,
Deputy Chief Actuary.

JUNE 5, 1974.

G. CHAIRMAN'S LETTER TO GENERAL ACCOUNTING OFFICE REQUESTING STUDY OF BENEFICIARY REHABILITATION PROGRAM

COMMITTEE ON WAYS AND MEANS,
HOUSE OF REPRESENTATIVES,
Washington, D.C., April 25, 1974.

Hon. ELMER B. STAATS,
Comptroller General of the United States,
Washington, D.C.

DEAR MR. STAATS: The staff of the Committee on Ways and Means is presently conducting a thorough review of the social security disability insurance program. One of the issues it is looking into is the effectiveness of the beneficiary rehabilitation program, which is intended to enable social security disability insurance beneficiaries to return to employment and consequently reduce substantial future payments of trust funds. This program, as you know, is financed with social security trust funds and is administered by the Rehabilitation Services Administration, Social and Rehabilitation Service. The program has grown rather dramatically in recent years and significant savings to the trust funds have been claimed for the program.

It is my understanding that the General Accounting Office (GAO) is conducting a survey of this program with particular emphasis on expenditures, savings, and criteria for client processing. While GAO may already be addressing itself to areas in which the committee is interested, I would like GAO to consider the following questions:

1. How do the Social Security Administration and the Rehabilitation Services Administration coordinate the operation and management of the beneficiary rehabilitation program?

2. Are the criteria used to select clients for referral under the basic vocational rehabilitation program and the criteria used in selecting clients for social security trust fund financed services reasonable and consistent? Are beneficiary rehabilitation program savings computations based on current and accurate data? How is this data used and are the actuarial assumptions consistent with the manner in which the program is administered?

3. Rehabilitation Services Administration emphasizes "rehabilitation" in its statistical reporting whereas the beneficiary rehabilitation program has a primary goal the "recovery" of individuals in order that they can return to competitive employment. Are these program goals consistent and does the vocational rehabilitation program, as administered by Rehabilitation Services Administration assist the clients to and through the recovery stage?

4. Are clients who are accepted for vocational rehabilitation services, which are financed with trust funds, those clients who would probably have recovered within a short time without these services?

5. Do State vocational rehabilitation agencies adequately distinguish between the beneficiary rehabilitation and the basic vocational rehabilitation programs? Should there be a distinction?

I would be particularly interested in an overall determination of the impact of the vocational rehabilitation services on termination of social security benefits.

Since the committee will be considering these matters in the near future, I would appreciate your giving the highest priority to furnishing information on the questions I have asked.

Sincerely yours,

WILBUR D. MILLS, *Chairman.*

5. General Program Statistics

A. COMPARATIVE SOCIAL SECURITY BENEFIT DATA

TABLE 67.—*Comparative benefit data for selected social security beneficiaries*

Type of beneficiary	Mar. 1974	Feb. 1974	Jan. 1974	Mar. 1973	Feb. 1973
Average monthly amount awarded:					
Retired workers	$182.65	$169.03	$179.25	$167.92	$176.48
Currently payable awards	171.74	159.67	173.99	156.31	170.11
Disabled workers	211.50	197.02	197.60	194.02	196.66
Benefits in current-payment status:					
Number of beneficiaries (in thousands)	30,103	29,886	29,966	28,749	28,759
Retired workers and dependents	18,953	18,827	18,892	18,025	18,049
Retired workers	15,513	15,424	15,458	14,684	14,700
Dependents	3,440	3,403	3,434	3,341	3,349
Disabled workers and dependents	3,611	3,575	3,562	3,341	3,322
Disabled workers	2,048	2,027	2,020	1,878	1,865
Dependents	1,563	1,548	1,542	1,463	1,456
Survivors of deceased workers	7,194	7,138	7,159	6,986	6,985
Widows and widowers	3,679	3,665	3,665	3,531	3,533
Children	2,925	2,887	2,899	2,888	2,881
Other survivors	591	587	595	567	571
Special age-72 beneficiaries	344	346	354	397	403
Aged 65 and over	19,578	19,460	19,525	18,729	18,764
Retired workers	13,912	13,844	13,867	13,203	13,225
Survivors and dependents	5,322	5,271	5,305	5,130	5,136
Special age-72 beneficiaries	344	346	354	397	403
Aged 62 to 64	2,894	2,853	3,878	2,653	20652
Retired workers	1,601	1,580	1,591	1,482	1,475
Disabled workers	428	424	421	322	322
Survivors and dependents	865	849	866	849	855
Under age 62	7,631	7,572	7,653	7,367	7,343
Disabled workers	1,620	1,603	1,598	1,557	1,543
Children	4,270	4,662	4,671	4,586	5,573
Under age 18	3,709	3,718	3,702	3,612	3,604
Disabled, aged 18 and over	316	312	311	300	299
Students aged 18 to 21	695	632	658	675	670
Other survivors and dependents [1]	1,291	1,307	1,293	1,225	1,227
Average monthly amount in payment status:					
Retired workers	$179.28	$167.04	$166.82	$164.30	$164.17
Disabled workers	196.66	183.45	183.29	180.46	180.22
Cash benefits paid (in millions)	$4,530	$4,421	$4,429	$4,267	$4,178
OASI	4,002	3,919	3,927	3,799	3,724
DI	528	502	502	468	454
Monthly benefits		4,396	4,408	4,232	4,151
Retired workers and dependents			2,843	2,714	2,660
Disabled workers and dependents			502	468	454
Survivors of decesaed workers			1,044	1,027	1,013
Special age-72 beneficiaries			20	23	23
Lump-sum death payments		25	21	34	27

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[1] Represents wives with entitled children, widowed mothers, and widows and widowers.

Source: Monthly Benefit Statistics, Office of Research and Statistics, SSA, June 11, 1974.

TABLE 68.—*Number and amount of monthly benefits in current-payment status at end of December 1973, by type of beneficiary and by region and State*

State 1/	Number of beneficiaries							Amount ($000) of monthly benefits 2/			
	Total	Retired workers	Disabled workers	Dependents of — Retired workers	Dependents of — Disabled workers	Survivors	Special age-72 benefi-ciaries	Total	Retired workers	Disabled workers	All other benefi-ciaries
Total	29,868,761	15,364,630	2,016,626	3,421,786	1,542,356	7,165,304	358,059	4,269,858	2,556,959	369,090	1,343,809
BOSTON	1,700,870	977,466	96,219	157,345	63,486	383,760	22,594	262,738	170,362	17,826	74,549
Connecticut	395,563	227,744	22,152	36,397	r 13,179	90,349	5,742	64,891	42,340	4,278	18,272
Maine	169,912	93,460	10,667	17,973	8,956	37,239	1,617	23,519	14,702	1,873	6,944
Massachusetts	807,199	466,167	43,671	73,057	28,101	185,216	10,987	124,998	81,132	8,106	35,760
New Hampshire	115,023	68,868	5,847	10,452	4,149	24,383	1,384	17,479	11,705	1,082	4,692
Rhode Island	144,103	84,009	9,670	11,715	5,757	31,028	1,924	22,055	14,400	1,740	5,914
Vermont	69,070	37,278	4,212	7,751	3,344	15,545	940	9,797	6,083	747	2,967
NEW YORK CITY	3,972,328	2,123,206	262,380	421,090	207,628	909,750	48,274	598,862	375,708	47,844	175,309
New Jersey	973,466	534,861	61,386	91,343	37,315	236,485	12,076	156,212	97,668	11,848	46,695
New York	2,592,140	1,453,164	161,379	248,374	100,221	592,842	36,160	412,053	263,688	30,643	117,722
Puerto Rico	401,830	133,100	39,383	80,714	69,826	78,770	37	30,057	14,043	5,315	10,700
Virgin Islands	4,892	2,081	232	659	266	1,653	1	540	310	38	192
PHILADELPHIA	3,273,644	1,632,744	232,294	354,297	163,548	846,526	44,235	478,691	276,226	43,216	159,250
Delaware	69,819	36,069	4,807	6,497	3,192	18,504	750	10,506	6,236	896	3,374
Dist. of Columbia	85,262	44,550	6,884	6,035	3,246	23,058	1,489	11,058	6,671	1,105	3,282
Maryland	433,966	222,496	27,417	41,066	17,061	119,249	6,677	63,408	37,282	5,086	21,041
Pennsylvania	1,770,849	923,263	114,763	194,769	69,678	446,165	22,211	273,437	162,734	21,899	88,804
Virginia	584,756	275,095	46,044	62,119	36,304	155,554	9,640	76,226	42,084	7,991	26,152
West Virginia	328,992	131,271	32,379	43,811	34,067	83,996	3,468	44,056	21,218	6,240	16,598
ATLANTA	5,213,693	2,517,599	413,075	611,131	334,576	1,282,879	54,433	669,052	383,298	70,568	215,185
Alabama	538,235	227,738	45,715	70,025	40,505	151,059	3,193	64,896	33,064	7,842	23,990
Florida	1,477,480	861,239	88,429	174,973	57,903	280,804	14,132	218,819	144,924	16,227	57,668
Georgia	615,409	270,138	58,733	59,333	46,910	172,583	7,712	74,707	38,885	9,744	26,077
Kentucky	524,983	233,223	40,778	72,014	43,679	130,681	4,608	64,657	34,274	7,179	23,204
Mississippi	371,468	156,070	32,330	50,814	31,472	98,211	2,571	39,631	20,346	5,137	14,149
North Carolina	718,237	335,176	60,724	75,107	44,030	194,022	9,178	88,623	49,021	9,995	29,608
South Carolina	356,641	152,835	35,160	32,137	27,096	104,890	4,523	43,029	22,215	5,823	14,991
Tennessee	611,240	281,180	51,206	76,728	42,981	150,629	8,516	74,689	40,570	8,621	25,498
CHICAGO	5,977,180	3,117,129	361,887	684,817	265,525	1,474,099	73,723	905,360	542,532	69,945	292,883
Illinois	1,458,604	785,834	82,331	152,400	52,398	364,686	20,955	224,334	138,264	15,746	70,323
Indiana	715,531	376,061	43,265	79,660	34,312	174,872	7,361	108,117	65,171	8,350	34,596
Michigan	1,175,478	584,597	83,777	133,760	62,920	299,253	11,171	182,788	105,698	16,702	60,387
Minnesota	547,236	302,169	23,913	72,956	18,073	120,555	9,570	77,289	48,782	4,404	24,103
Ohio	1,411,763	701,895	93,052	164,577	70,830	366,252	15,157	212,629	121,752	17,990	72,887
Wisconsin	668,568	366,573	35,549	81,464	26,992	148,481	9,509	100,204	62,864	6,753	30,587
KANSAS CITY	1,789,373	969,779	95,360	227,735	70,474	398,226	27,799	253,595	157,227	17,180	79,188
Iowa	453,510	246,370	21,510	61,364	15,715	99,900	8,651	65,332	40,567	3,943	20,823
Kansas	341,232	188,394	15,457	44,679	10,766	75,587	6,349	48,958	30,784	2,815	15,359
Missouri	763,262	406,303	48,632	90,724	37,141	172,195	8,267	106,814	65,239	8,705	32,871
Nebraska	231,369	128,712	9,761	30,968	6,852	50,544	4,532	32,491	20,637	1,718	10,136
DALLAS	2,925,517	1,347,817	209,548	392,516	197,033	747,931	30,672	368,563	202,138	36,607	129,818
Arkansas	375,218	172,910	32,182	53,224	29,659	82,545	4,698	43,829	24,173	5,351	14,305
Louisiana	499,322	194,806	42,921	63,358	47,666	144,620	5,951	59,881	28,702	7,492	23,687
New Mexico	136,018	58,223	10,144	18,008	12,968	35,202	1,473	16,728	9,011	1,824	5,893
Oklahoma	417,317	210,029	29,897	55,049	24,295	94,114	3,933	55,336	32,279	5,245	17,810
Texas	1,497,642	711,849	94,404	202,877	82,445	391,450	14,617	192,791	107,973	16,695	68,123
DENVER	737,500	383,344	40,183	95,475	32,223	176,186	10,089	102,552	61,630	7,273	33,649
Colorado	267,134	138,247	15,562	31,849	12,293	65,730	3,453	37,582	22,342	2,871	12,369
Montana	103,037	52,561	6,637	12,261	5,400	24,764	1,414	14,537	8,593	1,213	4,731
North Dakota	95,407	49,734	4,153	15,301	3,484	21,201	1,534	12,495	7,629	687	4,179
South Dakota	109,912	57,752	5,024	16,100	4,043	24,869	2,124	14,429	8,827	843	4,759
Utah	118,759	61,613	6,530	14,954	5,383	29,291	988	17,349	10,429	1,250	5,670
Wyoming	43,251	23,437	2,277	5,010	1,620	10,331	576	6,159	3,810	409	1,940
SAN FRANCISCO	3,062,671	1,642,259	236,848	324,635	157,109	666,114	35,706	455,219	278,656	45,551	131,012
Arizona	283,384	148,922	19,645	34,006	15,353	63,195	2,263	41,143	25,353	3,738	12,052
California	2,636,698	1,420,382	207,642	272,463	134,819	569,586	31,806	394,206	241,208	40,019	112,978
Hawaii	82,224	41,607	4,711	12,836	3,794	18,122	1,154	11,202	6,924	874	3,404
Nevada	57,214	30,728	4,677	4,742	2,788	13,799	480	8,461	5,096	898	2,467
American Samoa	1,504	241	74	342	223	622	2	75	26	8	41
Guam	1,647	379	99	246	132	790	1	131	49	13	69
SEATTLE	939,195	521,412	62,029	102,464	43,262	199,506	10,522	140,941	88,816	11,838	40,287
Alaska	15,861	6,232	1,034	1,539	1,156	5,846	54	2,007	1,015	201	791
Idaho	107,482	56,744	7,029	13,562	5,472	23,511	1,164	15,078	9,143	1,279	4,656
Oregon	340,636	192,836	23,885	36,449	15,943	67,898	3,625	51,399	32,785	4,547	14,067
Washington	475,216	265,600	30,081	50,914	20,691	102,251	5,679	72,436	45,873	5,811	20,772
ABROAD	276,790	131,875	6,803	50,281	7,492	80,327	12	34,287	20,366	1,241	12,680

1/ Beneficiary's State of residence.

2/ Benefits to retired worker beneficiaries and their dependents and to survivors of deceased workers are payable from the OASI trust fund. Benefits to disabled workers and their dependents are payable from the DI trust fund.

Source: Office of Research and Statistics—June 1974; RS:S-2.15a

B. SELECTED DATA ON DISABILITY

TABLE 69.—*Selected data on disability*

		1959	1960	1961	1962	1963	1964
	I. INITIAL DISABILITY CLAIMS						
1	A. Number of claims decided [1]	495, 100	373, 500	467, 000	457, 200	465, 400	441, 800
2	B. Claims requiring determination of disability.[2]	296, 900	310, 300	378, 200	393, 600	379, 800	368, 700
3	Worker	264, 800	278, 700	352, 200	362, 800	350, 900	341, 200
4	Widow						
5	Child	32, 100	31, 600	26, 000	30, 800	28, 900	27, 500
6	C. Number of claims allowed [3]	202, 100	217, 500	246, 200	276, 700	266, 800	240, 900
7	Worker [4]	173, 800	189, 600	224, 100	250, 100	242, 800	219, 200
8	Widow						
9	Child	28, 300	27, 900	22, 100	26, 600	24, 000	21, 700
10	D. Number allowed as percent of I.B. [3]	68. 1	70. 1	65. 1	70. 3	70. 2	65. 3
11	Worker	65. 6	68. 0	63. 6	68. 9	69. 2	64. 2
12	Widow						
13	Child	88. 2	88. 3	85. 0	86. 4	83. 0	78. 9
14	E. Number allowed on initial determination	183, 400	199, 700	230, 500	254, 100	249, 200	219, 200
15	Worker	155, 800	172, 500	208, 800	227, 900	225, 600	197, 800
16	Widow						
17	Child	27, 600	27, 200	21, 700	26, 200	23, 600	21, 400
18	F. Allowed on initial determination as percent	90. 7	91. 8	93. 6	91. 8	93. 4	91. 8
19	Worker	89. 6	91. 0	93. 2	91. 1	92. 9	91. 1
20	Widow						
21	Child	97. 5	97. 5	98. 2	98. 5	98. 3	98. 6
22	G. Cases initially denied—all reasons	311, 700	173, 800	236, 500	203, 100	216, 200	222, 600
23	Worker	306, 500	168, 600	231, 300	198, 100	210, 600	216, 100
24	Widow						
25	Child	5, 200	5, 200	5, 200	5, 000	5, 600	6, 500
26	H. Denied for failure to meet disability test	113, 500	110, 600	147, 700	139, 500	130, 600	149, 500
27	Worker	109, 000	106, 200	143, 400	134, 900	125, 300	143, 400
28	Widow						
29	Child	4, 500	4, 400	4, 300	4, 600	5, 300	6, 100
	II. RECONSIDERATION						
30	A. Number of determinations in initial claims	42, 200	35, 700	39, 200	58, 200	43, 400	51, 500
31	Worker	40, 900	34, 300	38, 100	57, 100	42, 400	50, 300
32	Widow						
33	Child	1, 300	1, 400	1, 100	1, 100	1, 000	1, 200
34	B. Number allowed after reconsideration	15, 100	15, 900	13, 500	19, 800	13, 900	15, 400
35	Worker	14, 600	15, 200	13, 100	19, 400	13, 500	15, 100
36	Widow						
37	Child	500	700	400	400	400	300
38	C. Allowed after reconsideration as percent of II. A.	35. 8	44. 5	34. 4	34. 0	32. 0	29. 9
39	Worker	35. 7	44. 3	34. 4	33. 9	31. 8	30. 0
40	Widow						
41	Child	38. 5	50. 0	36. 4	36. 4	40. 0	25. 0

See footnotes at end of table.

PROGRAM, 1957–73—ALL LEVELS

benefit program, fiscal years 1959–73

1965	1966	1967	1968	1969	1970	1971	1972	1973	
524,700	527,800	563,200	638,900	799,300	765,800	952,900	1,016,100	1,024,500	1
480,900	435,400	465,900	516,300	647,900	609,500	762,700	836,700	852,000	2
453,300	407,800	437,800	463,400	554,700	542,800	687,200	754,800	765,900	3
			25,400	62,200	37,600	42,000	44,700	47,000	4
27,600	27,600	28,100	27,500	31,000	29,100	33,500	37,200	39,100	5
275,400	307,100	326,300	394,300	406,800	382,300	456,200	505,300	537,300	6
253,600	284,800	303,800	314,800	356,700	344,400	414,600	461,300	488,100	7
			12,600	26,100	16,200	17,200	18,300	20,200	8
21,800	22,300	22,500	21,900	24,000	21,700	24,400	25,700	29,000	9
57.3	70.6	70.0	67.7	62.8	62.7	59.8	60.4	63.1	10
55.9	69.8	69.4	67.9	64.3	63.4	60.3	61.1	63.7	11
			49.6	41.9	43.1	40.9	40.9	43.0	12
78.9	80.8	80.1	79.6	77.4	74.6	72.8	69.1	74.2	13
249,400	274,700	296,700	317,400	364,700	335,500	395,100	426,800	449,200	14
228,000	252,700	274,500	283,200	316,300	299,900	356,100	385,900	403,700	15
			12,600	24,700	14,300	15,100	15,900	17,400	16
21,400	22,000	22,200	21,600	23,700	21,300	23,900	25,000	28,100	17
90.6	89.4	90.9	90.9	89.7	87.8	86.6	84.5	83.9	18
89.9	88.7	90.4	90.0	88.7	87.1	85.9	83.6	83.0	19
			100.0	94.6	88.3	87.8	86.9	86.6	20
98.2	98.7	98.7	98.6	98.8	98.2	97.9	97.3	96.9	21
275,300	253,100	266,500	321,700	434,600	430,300	557,800	589,300	575,300	22
269,100	247,000	260,100	301,900	387,000	396,900	518,900	545,900	533,000	23
			13,300	39,600	24,900	28,500	30,300	30,800	24
6,200	6,100	6,400	6,500	8,000	8,500	10,400	13,100	11,500	25
231,500	160,700	169,200	198,900	283,200	274,000	367,600	409,900	402,800	26
225,300	155,100	163,300	180,200	238,500	242,900	331,100	368,900	362,200	27
			12,800	37,400	23,300	26,[illegible]	28,800	29,600	28
6,200	5,600	5,900	5,900	7,300	7,800	9,600	12,200	11,000	29
61,500	59,900	58,100	67,400	96,200	97,700	116,800	159,500	156,800	30
60,200	58,900	57,400	66,500	88,700	91,200	108,900	149,000	146,600	31
				6,300	5,200	6,400	8,200	7,800	32
1,300	1,000	700	900	1,200	1,300	1,500	2,300	2,400	33
19,200	23,000	21,600	23,400	31,200	32,300	44,100	58,200	61,900	34
18,800	22,700	21,300	23,100	29,500	30,700	42,000	55,600	58,900	35
				1,400	1,200	1,600	1,900	2,100	36
400	300	300	300	300	400	500	700	900	37
31.2	38.4	37.2	34.7	32.4	33.1	37.8	36.5	39.5	38
31.2	38.5	37.1	34.7	33.3	33.7	38.6	37.3	40.2	39
				22.2	23.1	25.0	23.2	26.9	40
30.8	30.0	42.9	33.3	25.0	30.8	33.3	30.4	37.5	41

TABLE 69.—*Selected data on disability*

		1959	1960	1961	1962	1963	1964
	III. BHA ACTION IN INITIAL CLAIMS						
42	A. Number of hearings cases in which action was taken	16, 300	12, 200	9, 000	13, 100	16, 600	19, 400
43	Worker and Child	16, 300	12, 200	9, 000	13, 100	16, 600	19, 400
44	Widow						
45	B. Number allowed by ALJ's	3, 600	1, 900	2, 000	2, 500	3, 300	5, 500
46	Worker and Child	3, 600	1, 900	2, 000	2, 500	3, 300	5, 500
47	Widow						
48	C. Number allowed by Appeals Council	(5)	(5)	200	100	300	500
49	D. Total allowed as percent of total actions taken (B+C)÷A.	22. 1	15. 6	24. 4	19. 8	21. 7	39. 9
	IV. COURT ACTIONS						
50	A. Number of court actions filed	(5)	(5)	(5)	564	410	1, 003
51	B. Number of dispositions (including dismissals).	(5)	(5)	(5)	759	551	644
52	C. Cases allowed after court action	(5)	(5)	(5)	89	62	154
53	D. Allowed by Appeals Council after remand	(5)	(5)	(5)	68	50	99
54	E. Total allowed	(5)	(5)	(5)	157	112	253
55	F. Total allowed as percent of IV. B	(5)	(5)	(5)	20. 7	20. 3	39. 3
	V. CONTINUING DISABILITY CASES						
56	A. Number of investigations	84, 700	77, 700	85, 300	80, 900	96, 800	114, 800
57	Worker	83, 600	76, 600	83, 900	79, 600	94, 800	112, 400
58	Widow						
59	Child	1, 100	1, 100	1, 400	1, 300	2, 000	2, 400
60	B. Number terminated	10, 400	11, 600	14, 600	9, 100	13, 600	18, 100
61	Worker	10, 300	11, 500	14, 400	8, 900	13, 100	17, 400
62	Widow						
63	Child	100	100	200	200	500	700
64	C. Terminated cases as percent of V.A	12. 3	14. 9	17. 1	11. 2	14. 0	15. 8
65	Worker	12. 3	15. 0	17. 2	11. 2	13. 8	15. 5
66	Widow						
67	Child	9. 1	9. 1	14. 3	15. 4	25. 0	29. 2
	VI. WORK PENDING AT END OF FISCAL YEAR						
68	A. Initial claims—all stations	112, 300	79, 600	123, 800	102, 900	90, 200	93, 100
69	In district offices	42, 200	36, 700	60, 100	56, 800	47, 600	47, 100
70	In State agencies	53, 700	34, 300	50, 000	37, 200	32, 800	38, 300
71	In BDI	16, 400	8, 600	13, 700	8, 900	[illegible]	7, 700
72	B. Reconsiderations	10, 900	(5)	15, 200	10, 100	11, 400	15, 400
73	C. Hearings	9, 600	(5)	5, 100	9, 400	6, 700	5, 000
74	D. Court actions	(5)	(5)	(5)	800	1, 000	1, 300

benefit program, fiscal years 1959–73—Continued

1965	1966	1967	1968	1969	1970	1971	1972	1973	
19, 600	20, 400,	16, 200	20, 200	25, 600	31, 300	37, 100	43, 900	53, 100	42
19, 600	20, 400	16, 200	20, 200	25, 600	29, 100	35, 100	41, 800	50, 600	43
					2, 200	2, 000	2, 100	2, 500	44
5, 800	7, 800	6, 400	7, 900	9, 800	13, 300	15, 800	19, 200	24, 100	45
5, 800	7, 800	6, 400	7, 900	9, 800	12, 600	15, 300	18, 700	23, 400	46
					700	500	500	700	47
600	1, 100	1, 000	600	600	800	750	700	1, 600	48
32. 7	43. 6	45. 7	42. 1	40. 6	45. 0	44. 6	45. 3	48. 4	49
897	873	798	916	1, 200	1, 361	1, 423	1, 700	2, 004	50
952	964	999	692	828	1, 014	1, 262	1, 200	1, 556	51
262	232	170	102	116	162	160	150	172	52
147	257	415	211	165	211	297	200	318	53
408	489	585	313	281	373	457	350	490	54
42. 9	50. 7	58. 6	45. 2	33. 9	36. 8	36. 2	29. 2	31. 5	55
145, 200	103, 500	160, 100	152, 900	149, 600	166, 700	151, 700	167, 200	179, 000	56
142, 000	100, 300	156, 400	149, 200	146, 100	162, 600	148, 200	161, 900	173, 600	57
							900	900	58
3, 200	3, 200	3, 700	3, 700	3, 500	4, 100	3, 500	4, 400	4, 500	59
19, 300	18, 700	33, 300	34, 900	39, 400	43, 300	37, 900	39, 100	(5)	60
18, 500	17, 700	31, 900	33, 300	37, 800	41, 400	36, 400	36, 900	(5)	61
							300	(5)	62
800	1, 000	1, 400	1, 600	1, 600	1, 900	1, 500	1, 900	(5)	63
13. 3	18. 1	20. 8	22. 8	26. 3	26. 0	25. 0	23. 4	(5)	64
13. 0	17. 6	20. 4	22. 3	25. 9	25. 5	24. 6	22. 8	(5)	65
							33. 3	(5)	66
25. 0	31. 3	37. 8	43. 2	45. 7	46. 3	42. 9	43. 2	(5)	67
97, 700	131, 200	105, 900	163, 100	131, 100	193, 300	185, 400	158, 300	197, 000	68
51, 500	70, [illegible]00	59, 500	85, 100	71, 100	112, 900	74, 200	42, 500	54, 700	69
39, 100	45, 200	36, 600	53, 600	43, 200	66, 200	97, 700	109, 300	119, 500	70
7, 100	15, 600	9, 800	24, 400	16, 800	14, 200	13, 500	6, 500	22, 800	71
18, 200	20, 900	20, 500	25, 900	33, 200	34, 100	27, 900	21, 300	24, 300	72
4, 900	4, 300	4, 600	5, 700	9, 700	10, 300	13, 000	24, 500	23, 600	73
1, 200	1, 100	900	1, 100	1, 500	1, 900	2, 000	2, 400	2, 900	74

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[1] Sum of cases initially allowed and initially denied (E+G).

[2] Sum of cases initially allowed and initially denied for failure to meet disability test (E+H).

[3] Includes all allowances—initial, reconsideration, hearing, and court action.

[4] May include a few hearing reversals in childhood disability cases.

[5] Not available.

TA..LE 70.—*Number and average monthly amount of disabled worker benefits in current-payment status and percentage distribution by amount of benefit, by State, at end of December 1973*

State 1/	Average benefit	Number of benefi-ciaries	Percent of beneficiaries receiving --											
			Total	$84.40 and under	$84.50	$84.60 -99.90	$100.00 -119.90	$120.00 -139.90	$140.00 -159.90	$160.00 -179.90	$180.00 -199.90	$200.00 -219.90	$220.00 -239.90	$240.00 and over
Total.......	$183.02	2,016,626	100.0	.5	3.9	2.8	5.4	12.0	12.1	10.7	10.7	11.4	12.9	17.6
Michigan..........	199.37	83,777	100.0	.7	2.0	1.8	3.7	8.4	9.1	8.2	9.5	12.1	17.0	27.5
Alaska...........	194.24	1,034	100.0	.4	2.2	1.9	5.0	7.3	8.0	13.2	12.5	13.3	15.6	20.6
Ohio.............	193.33	93,052	100.0	.6	2.6	2.2	4.3	9.8	10.3	9.1	10.0	12.0	15.0	24.1
Washington........	193.19	30,081	100.0	.9	2.4	2.1	4.1	9.3	10.0	9.3	10.9	13.1	15.4	22.5
Connecticut.......	193.13	22,152	100.0	.5	1.7	1.6	3.9	10.1	11.3	10.4	11.1	12.9	14.9	21.6
New Jersey........	193.01	61,386	100.0	.3	1.9	1.9	4.3	10.5	11.1	10.0	10.5	11.6	14.9	23.0
Indiana...........	192.99	43,265	100.0	.2	3.0	2.2	4.2	9.7	10.1	9.7	10.6	12.1	15.4	22.8
California........	192.73	207,642	100.0	.5	2.2	2.0	4.1	9.8	10.7	9.8	10.8	13.2	15.8	21.1
West Virginia.....	192.71	32,379	100.0	.3	2.7	1.9	4.1	9.2	10.1	9.6	11.1	14.7	16.5	19.8
Nevada............	192.02	4,677	100.0	1.0	1.7	1.8	3.7	10.2	11.2	10.2	10.8	13.3	15.1	21.0
Utah..............	191.38	6,530	100.0	.5	2.8	2.3	4.3	10.6	10.5	9.2	10.6	11.5	16.0	21.7
Illinois..........	191.26	82,331	100.0	.2	2.2	2.0	4.5	10.7	11.6	10.3	11.1	12.0	14.2	21.2
Pennsylvania......	190.82	114,763	100.0	.3	2.4	2.0	4.3	10.3	11.2	10.5	11.2	12.6	15.0	20.2
Oregon............	190.35	23,885	100.0	1.0	2.4	2.4	4.3	9.9	10.5	9.5	11.0	13.3	15.6	20.1
Arizona...........	190.26	19,645	100.0	.8	2.5	2.4	4.3	9.9	10.6	9.4	11.0	13.7	16.4	19.0
Wisconsin.........	189.95	35,549	100.0	.3	3.3	2.4	4.7	10.6	10.8	9.6	10.4	12.0	14.7	21.2
New York..........	189.88	161,379	100.0	.4	2.0	2.0	4.6	11.3	12.0	10.7	10.7	11.6	13.8	20.9
Delaware..........	186.49	4,807	100.0	.5	2.5	2.9	5.7	12.6	11.8	10.0	9.5	10.7	12.6	21.2
Massachusetts.....	185.60	43,671	100.0	.8	1.7	2.0	4.9	12.3	13.1	11.8	11.0	11.9	13.1	17.4
Maryland..........	185.49	27,417	100.0	.5	3.2	2.7	5.6	12.0	11.7	10.4	10.0	11.2	13.5	19.2
Hawaii............	185.43	4,711	100.0	1.1	4.0	2.6	4.5	10.4	12.1	10.4	11.1	11.1	13.4	19.3
New Hampshire.....	185.08	5,847	100.0	.8	1.9	1.8	4.4	11.6	13.5	12.3	12.2	12.4	13.6	15.5
Colorado..........	184.51	15,562	100.0	.2	3.4	2.7	5.3	11.9	12.2	10.9	10.9	12.1	13.2	17.2
Minnesota.........	184.17	23,913	100.0	.6	3.7	2.8	5.5	12.0	12.1	10.0	10.2	11.4	13.2	18.5
Florida...........	183.51	88,429	100.0	.6	3.6	3.1	5.6	11.5	11.6	10.6	10.8	11.6	13.4	17.6
Iowa..............	183.29	21,510	100.0	.3	4.0	3.1	5.4	12.0	11.8	10.3	10.9	11.6	13.3	17.3
Montana...........	182.72	6,637	100.0	.5	4.3	2.8	5.7	11.9	11.7	9.7	11.2	12.4	14.4	15.4
Kansas............	182.14	15,467	100.0	.3	4.1	2.8	5.3	12.4	12.3	10.3	11.4	12.4	12.5	16.2
Idaho.............	182.02	7,029	100.0	.6	3.7	3.0	5.5	12.0	11.3	10.7	11.3	13.0	13.5	15.4
Rhode Island......	179.97	9,670	100.0	.7	1.6	2.0	5.9	13.4	14.7	13.1	11.6	11.8	11.4	13.8
New Mexico........	179.83	10,144	100.0	.5	3.7	3.6	6.2	12.4	12.1	10.5	11.2	12.3	13.2	14.3
Wyoming...........	179.80	2,277	100.0	.4	4.5	3.3	5.2	14.6	12.1	10.1	9.7	11.6	12.5	16.0
Missouri..........	178.99	48,632	100.0	.2	4.7	3.2	6.1	13.2	12.8	11.0	10.4	10.9	11.9	15.6
Vermont...........	177.33	4,212	100.0	.5	2.9	2.8	6.1	13.3	13.8	12.5	12.7	12.2	11.5	11.7
Texas.............	176.85	94,404	100.0	.5	4.9	3.6	6.4	13.2	12.7	11.1	10.8	10.7	11.3	14.8
Kentucky..........	176.06	40.778	100.0	.8	4.6	3.5	6.3	13.0	12.7	11.4	11.7	11.5	11.2	13.3
Nebraska..........	175.97	9,761	100.0	.3	4.8	3.4	5.8	14.4	13.2	11.1	11.4	11.3	11.8	12.5
Maine.............	175.61	10,667	100.0	.6	2.9	3.0	5.9	13.5	14.7	14.0	12.7	11.2	10.6	10.9
Oklahoma..........	175.44	29,897	100.0	.4	4.5	3.7	6.5	13.3	12.9	11.4	12.0	11.7	11.5	12.1
Louisiana.........	174.56	42,921	100.0	.7	6.1	4.0	6.8	13.5	12.5	10.5	10.0	10.0	11.3	14.6
Virginia..........	173.54	46,044	100.0	.4	4.8	3.5	6.8	14.3	13.8	11.8	11.3	10.7	10.4	12.2
Alabama...........	171.53	45,715	100.0	.5	6.3	3.9	6.8	13.9	14.1	11.4	10.4	10.1	10.1	12.5
Tennessee.........	168.37	51,206	100.0	.5	6.1	4.2	7.2	15.7	14.4	11.8	10.5	9.3	9.4	10.9
South Dakota......	167.74	5,024	100.0	.4	7.4	4.5	6.4	15.8	13.0	11.5	11.4	10.1	9.6	9.9
Arkansas..........	166.26	32,182	100.0	.7	7.2	4.6	7.3	14.9	14.0	11.9	11.0	9.8	9.0	9.6
Georgia...........	165.91	58,733	100.0	.4	5.8	4.2	7.6	16.1	15.7	13.4	10.8	8.7	7.8	9.5
South Carolina....	165.61	35,160	100.0	.4	6.2	3.7	6.8	15.1	15.8	14.7	12.7	9.3	7.6	7.7
North Dakota......	165.35	4,153	100.0	.7	8.1	3.8	7.7	16.5	13.1	11.4	10.3	9.6	9.4	9.4
North Carolina....	164.60	60,724	100.0	.3	6.1	4.2	7.7	15.9	15.6	13.7	11.6	9.4	7.6	7.9
Dist. of Columbia.	160.51	6,884	100.0	.6	5.2	4.1	7.9	19.2	16.9	14.5	10.7	8.6	6.4	5.9
Mississippi.......	158.88	32,330	100.0	.5	9.9	5.3	8.2	16.5	15.2	11.4	9.6	8.3	7.2	7.9
Other areas:														
Virgin Islands..	163.51	232	100.0	.9	6.5	4.7	5.2	20.3	17.7	11.6	8.6	6.9	4.7	12.9
Guam............	135.85	99	100.9	0	23.3	12.1	7.1	13.1	19.2	6.1	4.0	7.1	4.0	4.0
Puerto Rico.....	134.95	39,383	100.0	2.2	21.6	6.6	9.0	19.8	14.5	9.0	6.7	4.8	3.3	2.5
American Samoa..	114.76	74	100.0	4.1	32.3	14.9	12.2	18.8	4.1	2.7	4.1	2.7	4.1	0
Abroad............	182.49	6,803	100.0	.5	1.9	1.9	3.7	12.5	14.0	12.2	14.0	14.5	14.2	10.6

1/ Beneficiary's State of residence.

Source: Office of Research and Statistics—June 1974; RS:S-2.11

C. DISABLED WORKERS IN CURRENT-PAYMENT STATUS

TABLE 71.—*Disabled workers in current-payment status: Number by sex, 1957–73*

Year	Total	Male	Female
1957	149, 850	121, 172	28, 678
1958	237, 719	189, 883	47, 836
1959	334, 443	264, 201	70, 242
1960	455, 371	356, 277	99, 094
1961	618, 075	481, 989	136, 086
1962	740, 867	570, 016	170, 851
1963	827, 014	629, 038	197, 976
1964	894, 173	673, 791	220, 382
1965	988, 074	734, 047	254, 027
1966	1, 097, 190	808, 260	288, 930
1967	1, 193, 120	871, 864	321, 256
1968	1, 295, 300	939, 574	355, 726
1969	1, 394, 291	1, 003, 321	390, 970
1970	1, 492, 948	1, 068, 986	423, 962
1971	1, 647, 684	1, 175, 271	472, 413
1972	1, 832, 916	1, 300, 284	532, 632
1973	2, 016, 626	1, 417, 796	598, 830

TABLE 72.—*Disabled workers in current-payment status: Average benefits by sex, 1957–73*

Year	Total	Male	Female
1957	$72. 76	$73. 47	$69. 76
1958	82. 10	84. 99	70. 62
1959	89. 00	92. 42	76. 14
1960	89. 31	92. 72	77. 03
1961	89. 59	92. 89	77. 90
1962	89. 99	93. 49	78. 32
1963	90. 59	94. 28	78. 87
1964	91. 12	94. 96	79. 37
1965	97. 76	102. 10	85. 25
1966	98. 09	102. 62	85. 46
1967	98. 43	103. 14	85. 64
1968	111. 86	117. 42	97. 19
1969	112. 74	118. 66	97. 53
1970	131. 29	138. 63	112. 79
1971	146. 52	155. 25	124. 80
1972	179. 32	190. 84	151. 19
1973	183. 00	195. 80	152. 70

TABLE 73.—*Payments to disabled workers and dependents, 1957–73*

[In millions]

Year	Total	Disabled workers	Wives	Children
Total	$32, 987	$26, 557	$1, 784	$4, 646
1957	57	57		
1958	249	246	1	1
1959	457	390	29	38
1960	568	489	32	48
1961	887	724	54	109
1962	1, 105	888	68	149
1963	1, 210	965	73	172
1964	1, 309	1, 044	79	186
1965	1, 573	1, 246	95	232
1966	1, 781	1, 394	108	280
1967	1, 939	1, 519	113	307
1968	2, 294	1, 804	131	360
1969	2, 542	2, 014	139	389
1970	3, 067	2, 448	165	454
1971	3, 758	3, 028	192	539
1972	4, 473	3, 626	224	623
1973	5, 718	4, 676	281	760

HIGHLIGHTS OF 1973

During 1973, monthly cash benefit payments to disabled workers and dependents totalled $5.7 billion, some $1¼ billion more than during the preceding year. Disabled workers received $4.7 billion dollars, their wives received $280 million and their children received $760 million. The number of disabled workers who were in current-payment status at the end of December 1973 totalled nearly 2,020,000, a net increase during the year of about 195,000. The average monthly amount payable to disabled workers at the end of 1973 was $183, about $4 more than a year earlier.

Two out of every three workers on the rolls at the end of 1973 were disabled within the past 5 years.

Death came to 118,000 disabled workers in 1973.

White disabled workers averaged $188 a month while Negro disabled workers averaged $160 a month.

The average monthly benefit amount was highest for disabled workers living in Michigan—$199 a month. The average was lowest for disabled workers living in Mississippi—$159 a month. (The amount of the social security benefit is determined as a percentage of the worker's average monthly wage.)

The monthly benefit for disabled workers living in the areas of the Northeast, Northcentral, and Western States was nearly the same, averaging about $190, compared to a monthly benefit of $174 for disabled workers living in the South.

Only one out of every five disabled workers has a dependent wife in current-payment status.

D. Benefit Awards by State, Sex, Race, and Diagnosis for 1971

HIGHLIGHTS OF 1971—AWARDS TO DISABLED WORKERS

Among the disability applicants who were awarded benefits in 1971

Fifteen diseases accounted for more than 55 percent of the 416,000 disability awards during the year.

Ischemic heart diseases ranked as the number one cause of disability—being the basis for 20 percent of all disability awards.

The proportion disabled by ischemic heart disease was higher for Negro women (21.7 percent) than for Negro men (11.9 percent).

Median age was the same for both men and women—55 in 1971 and 56 in 1970.

The median age for disabled workers of all other races (Chinese, Japanese, Indians, etc.) and of Negroes was 54 years, about 2 years younger than for white workers.

Nearly 18 percent of the workers of all other races were disabled before reaching age 40, compared to 15 percent of the Negroes and 12 percent of the whites.

Six percent of the men were disabled before their 30th birthday compared to only 4 percent of the women.

Nearly 30 percent of all disability awards to workers under 30 were based on mental disorders compared to less than 6 percent for workers 55 years of age and over.

Eighty-five percent of the disabled workers were white, 14 percent were Negro, and 1 percent were of all other races.

About 35 percent of the workers disabled by pulmonary tuberculosis were Negro; however, only 6 percent of the workers disabled by emphysema were Negro.

Diabetes is one of the seven leading diseases underlying disability allowances and according to the Public Health Service the fifth leading cause of death.

Of all male workers disabled by diabetes, 80.0 percent were white, 16.6 percent Negro, and 3.4 percent of other races; among female workers disabled by diabetes 72.1 percent were white, 27.2 percent Negro, and 0.7 of other races.

According to the Bureau of the Census about 3.2 percent of all employed persons were working in agriculture. Yet, about 5.6 percent of the total number of disability awards in 1971 were to agricultural workers.

Whites and Negroes in construction work represented about 7 and 8 percent of the total labor force. However, among workers who were allowed disability benefits in 1971, about twice as many were employed in construction occupations (15 percent).

Of all Negro workers 28 percent are generally employed in service type occupations. However, among Negro workers who were allowed disability benefits in 1971 about 36 percent (3 percent less than in 1970) were employed as service workers. For white workers, 11 percent are generally employed in the service area and about 14 percent of those allowed disability benefits in 1971 were engaged in service type occupations.

WORKER DISABILITY ALLOWANCES, 1971

Leading States

	Number	Percent
1. California	48, 281	11. 6
2. New York	35, 994	8. 7
3. Pennsylvania	23, 939	5. 8
4. Ohio	20, 519	4. 9
5. Texas	19, 503	4. 7
6 Michigan	19, 351	4. 7
7 Illinois	18, 835	4. 5

Sex

	Number	Percent
Total	415, 897	100
Male	305, 328	73
Female	110, 569	27

Age

	Percent	
	1971	1970
60 and over	31	30
55 to 59	24	24
50 to 54	16	15
40 to 49	16	17
Under age 40	13	13

Age at onset of disability

	Percent
50 to 65	67
40 to 49	18
Under age 40	15

Visual or audio impairments

	Number
1. Statutory blindness	4, 885
2. Industrial blindness	808
3. Defective vision	578
4. Deafness	987

Cause by primary diagnosis and sex

	Number
Male:	
1. Chronic ischemic heart	67, 368
2. Emphysema	16, 019
3. Osteoarthritis	13, 902
Female:	
1. Chronic ischemic heart	17, 049
2. Osteoarthritis	7, 575
3. Schizophrenia	5, 070

Cause by primary diagnosis

	Number	Percent
Chronic ischemic heart	84, 417	20
Osteoarthritis	21, 477	5
Emphysema	18, 132	4
Schizophrenia	17, 545	4
Displacement of intervertebral disc	15, 968	4

Cause by primary diagnosis and age

	Number
Under age 40:	
1. Schizophrenia	8, 818
2. Displacement of intervertebral disc	3, 412
3. Chronic ischemic heart	1, 384
Aged 40 to 49:	
1. Chronic ischemic heart	11, 095
2. Schizophrenia	4, 660
3. Displacement of intervertebral disc	4, 432
Aged 50 to 54:	
1. Chronic ischemic heart	14, 523
2. Osteoarthritis	2, 632
3. Displacement of intervertebral disc	2, 567
Aged 55 to 59:	
1. Chronic ischemic heart	23, 879
2. Osteoarthritis	6, 659
3. Emphysema	5, 344
Aged 60 and over:	
1. Chronic ischemic heart	33, 536
2. Osteoarthritis	10, 282
3. Emphysema	8, 582

Cause by diagnostic group

	Number	Percent
Circulatory system	131,854	31. 7
Musculoskeletal system	66,558	16. 0
Mental disorders	42,687	10. 3
Neoplasms	39,629	9. 5
Accidents	31,810	7. 6
Respiratory system	30,103	7. 2
Nervous system and sense organs	26,442	6. 4
Endocrine, nutritional, and metabolic	15,823	3. 8
Digestive system	11,629	2. 8
Infective and parasitic	8,524	2. 0
Congenital anomalies	4,365	1. 0
Genitourinary	3,501	. 8
Other	2,972	. 7

Occupation

	Number	Percent
Service	66, 545	17. 4
Structural work	58, 207	15. 3
Clerical and sales	57, 399	15. 0
Professional and managerial	45, 838	12. 0
Machine trades	40, 747	10. 7
Transportation	26, 584	7. 0
Benchwork	26, 334	6. 9
Farming	21, 460	5. 6
Packaging and handling	15, 037	3. 9
Processing	13, 398	3. 5

Occupation by race

	Percent		
	White	Negro	Other
Service	14. 4	36. 3	24. 6
Structural work	15. 3	15. 2	15. 4
Clerical and sales	16. 7	5. 5	7. 4
Professional and managerial	13. 3	4. 5	6. 5
Machine trades	11. 4	6. 7	5. 8
Transportation	6. 7	8. 5	6. 4
Farming	5. 5	5. 6	14. 4
Benchwork	7. 1	5. 4	7. 0
Packaging and handling	3. 6	6. 2	5. 4
Processing	3. 3	4. 6	4. 8

Leading causes, by race (total)

White	Number	Negro	Number	Other races	Number
Chronic ischemic heart	72, 028	Chronic ischemic heart	11, 715	Chronic ischemic heart	674
Osteoarthritis	17, 823	Osteoarthritis	3, 308	Schizophrenia	367
Emphysema	16, 993	Schizophrenia	2, 950	Osteoarthritis	346
Schizophrenia	14, 228	Diabetes mellitus	2, 184	Diabetes mellitus	282
Displacement of intervertebral disc	13, 877	Displacement of intervertebral disc	1, 872	Displacement of intervertebral disc	219
Rheumatoid arthritis	9, 203	Pulmonary tuberculosis	1, 777	Cirrhosis of liver	1[illegible]

Leading causes, by race and sex

Male

White	Number	Negro	Number	Other races	Number
Chronic ischemic heart	58, 812	Chronic ischemic heart	8, 021	Chronic ischemic heart	535
Emphysema	15, 015	Schizophrenia	2, 215	Schizophrenia	279
Osteoarthritis	11, 605	Osteoarthritis	2, 019	Osteoarthritis	278
Displacement of intervertebral	10, 353	Pulmonary tuberculosis	1, 559	Diabetes mellitus	260
Schizophrenia	9, 981	Displacement of intervertebral disc	1, 512	Displacement of intervertebral disc	190
Diabetes mellitus	6, 200	Diabetes mellitus	1, 290	Cirrhosis of liver	132

Female

Chronic ischemic heart	13, 216	Chronic ischemic heart	3, 694	Chronic ischemic heart	139
Osteoarthritis	6, 218	Osteoarthritis	1, 289	Schizophrenia	88
Schizophrenia	4, 247	Diabetes mellitus	894	Osteoarthritis	68
Rheumatoid arthritis	4, 177	Schizophrenia	735	Rheumatoid arthritis	61
Displacement of intervertebral disc	3, 524	Cerebrovascular	492	Displacement of intervertebral disc	29
Neuroses	3, 033	Rheumatoid arthritis	443	Emphysema	25

Education by race

[In percent]

Highest grade	White	Negro	Other
8th grade or less	41	60	59
9th to 11th grades	24	22	16
High school (12th grade)	26	14	18
College (1 or more years)	10	4	7

Education by age

[Percent]

Highest grade	Age: Under 30	45 to 49	60 and over
8th grade or less	14	38	52
9th to 11th grades	26	26	21
High school (12th grade)	45	27	18
College (1 or more years)	15	9	9

CHILDHOOD DISABILITY ALLOWANCES—1971

Leading States

	Number	Percent
1. New York	2, 241	9
2. California	1, 945	7
3. Pennsylvania	1, 473	6
4. Texas	1, 445	5
5. Ohio	1, 270	5
6. Michigan	1, 229	5

Sex

	Number	Percent
Total	26, 301	100
Male	13, 042	50
Female	13, 259	50

Age

	Percent: 1971	1970
18 to 29	63	63
30 to 39	22	22
40 and over	15	15

Cause by diagnostic group

	Percent	Cumulative percent
Mental disorders	79	79
Nervous system and sense organs	13	92
Congenital anomalies	2	94
Infective and parasitic	2	96
Accidents	1	97
Other	3	100

Cause by primary diagnosis

	Percent	Cumulative percent
1. Unspecified mental retardation	48	48
2. Moderate mental retardation	9	56
3. Mild mental retardation	6	63
4. Schizophrenia	6	69
5. Cerebral spastic infantile paralysis	6	74
6. Severe mental retardation	4	78

Mobility of childhood beneficiaries

	Percent
Confined in an institution [1]	27
Housebound (bedridden, chairfast, etc.)	7
Capable of some activity outside the home [2]	66

[1] The proportion of persons in the different age groups who were confined in an institution ranged from 44 percent for persons aged 45 and over to 23 percent for persons under age 30.

[2] Of these, 39 percent needed help of some kind.

Education of childhood beneficiaries

	Percent
Had not attended a regular school	42
Completed the 5th grade or a higher grade of elementary school but did not attend high school	18
Attended elementary school for 1 or more years but did not advance beyond the 4th grade	13
Completed 1 or more years of high school	22
Attended ungraded special classes	5

TABLE 74.—*By State diagnostic group*

[Rate per 100,000 workers insured in event of disability]

State	Total	Infective and parasitic	Neoplasms	Endocrine, nutritional, and metabolic	Mental disorders	Nervous system and sense organs	Circulatory system	Respiratory system	Digestive system	Musculoskeletal system	Accidents	Other
United States	556	11	53	21	57	35	176	40	16	89	43	14
Alabama	822	26	73	22	66	43	278	60	20	139	69	25
Alaska	241	6	19	6	21	29	64	19	4	42	21	9
Arizona	583	11	54	17	72	32	153	64	16	109	43	15
Arkansas	1, 039	25	81	25	90	69	332	84	18	205	77	34
California	727	13	63	27	70	43	201	46	22	158	64	20
Colorado	500	6	45	18	49	37	114	50	14	93	57	17
Connecticut	443	7	51	19	54	30	144	22	16	60	31	9
Delaware	507	12	51	18	46	41	168	34	13	76	38	11
District of Columbia	429	9	37	33	43	33	126	18	15	63	45	8
Florida	723	19	72	28	70	46	242	46	23	111	45	20
Georgia	649	15	59	34	81	31	207	36	17	99	52	18
Hawaii	398	10	43	11	45	29	114	20	10	71	31	14
Idaho	673	7	58	20	39	49	185	57	13	157	75	13
Illinois	463	13	54	20	44	32	155	29	13	66	26	13
Indiana	507	12	50	20	41	38	164	40	11	79	37	15
Iowa	507	3	49	15	65	34	158	42	12	82	33	13
Kansas	464	6	63	14	52	36	134	37	11	65	36	11
Kentucky	732	20	64	18	66	48	240	93	18	99	51	16
Louisiana	879	25	57	23	77	53	303	55	21	163	83	19

Maine	706	10	59	25	77	43	220	75	25	109	42	20
Maryland	482	13	54	13	47	26	180	30	15	53	37	14
Massachusetts	523	11	57	17	61	38	167	32	14	79	38	10
Michigan	600	9	60	28	61	39	183	43	15	97	46	20
Minnesota	382	5	45	15	33	31	109	23	8	73	29	11
Mississippi	998	22	81	39	88	60	347	63	19	167	79	33
Missouri	598	11	59	25	73	40	188	52	16	82	40	11
Montana	658	9	54	27	47	53	176	63	11	138	59	20
Nebraska	394	6	54	22	49	26	105	25	7	63	27	11
Nevada	617	4	57	25	34	47	164	47	16	131	65	26
New Hampshire	475	5	53	19	55	34	154	37	13	61	31	14
New Jersey	543	14	58	24	61	33	184	30	17	74	33	14
New Mexico	773	7	51	33	78	50	155	74	23	196	80	26
New York	495	9	53	22	48	34	167	27	20	68	32	14
North Carolina	557	14	56	23	49	36	194	35	16	67	48	18
North Dakota	453	3	54	20	68	29	143	35	10	55	28	7
Ohio	565	11	47	22	53	40	192	45	16	88	40	13
Oklahoma	632	11	67	22	65	44	183	45	16	125	47	9
Oregon	679	10	51	14	55	41	182	58	11	151	85	20
Pennsylvania	551	13	50	22	54	34	190	53	15	74	57	9
Rhode Island	589	8	61	23	65	49	177	28	18	107	37	14
South Carolina	726	17	66	23	81	37	270	56	19	93	47	16
South Dakota	595	8	61	21	86	38	168	36	13	95	48	20
Tennessee	677	14	49	22	64	36	233	56	19	113	50	21
Texas	531	10	59	21	48	32	168	37	14	77	52	12
Utah	428	8	35	15	35	32	112	37	7	103	32	12
Vermont	580	9	58	26	58	30	166	58	13	99	47	14
Virginia	594	14	49	13	55	32	219	54	17	81	46	14
Washington	600	14	51	18	60	34	169	52	13	101	69	19
West Virginia	1, 085	19	64	36	103	49	306	214	28	152	88	27
Wisconsin	521	6	60	20	71	31	161	26	14	83	37	12
Wyoming	430	3	39	7	23	25	144	46	10	64	49	19

TABLE 75.—*Disability rates by diagnosis and by State*

State	Rate[1]	State	Rate	State	Rate
ALL DIAGNOSES (000–999)					
West Viginia	1,085	Nevada	617	Indiana	507
Arkansas	1,039	Michigan	600	Iowa	507
Mississippi	998	Washington	600	Colorado	500
Louisiana	879	Missouri	598	New York	495
Alabama	822	South Dakota	595	Maryland	482
New Mexico	773	Virginia	594	New Hampshire	475
Kentucky	732	Rhode Island	589	Kansas	464
California	727	Arizona	583	Illinois	463
South Carolina	726	Vermont	580	North Dakota	453
Florida	723	Ohio	565	Connecticut	443
Maine	706	North Carolina	557	Wyoming	430
Oregon	679	Pennsylvania	551	District of Columbia	429
Tennessee	677	New Jersey	543	Utah	428
Idaho	672	Texas	531	Hawaii	398
Montana	658	Massachusetts	523	Nebraska	394
Georgia	649	Wisconsin	521	Minnesota	382
Oklahoma	632	Delaware	507	Alaska	241
				United States[2]	556
CIRCULATORY SYSTEM (390–458)					
Mississippi	347	Idaho	185	Wisconsin	161
Arkansas	332	New Jersey	184	Iowa	158
West Virginia	306	Michigan	183	Illinois	155
Louisiana	303	Oklahoma	183	New Mexico	155
Alabama	278	Oregon	182	New Hampshire	154
South Carolina	270	Maryland	180	Arizona	153
Florida	242	Rhode Island	177	Connecticut	144
Kentucky	240	Montana	176	Wyoming	144
Tennessee	233	Washington	169	North Dakota	143
Maine	220	South Dakota	168	Kansas	134
Virginia	219	Delaware	168	District of Columbia	126
Georgia	207	Texas	168	Colorado	114
California	201	Massachusetts	167	Hawaii	114
North Carolina	194	New York	167	Utah	112
Ohio	192	Vermont	166	Minnesota	109
Pennsylvania	190	Indiana	164	Nebraska	105
Missouri	188	Nevada	164	Alaska	64
				United States[2]	176
MENTAL DISORDERS (295–315)					
West Virginia	103	Iowa	65	Nebraska	49
Arkansas	90	Oklahoma	65	North Carolina	49
Mississippi	88	Rhode Island	65	New York	48
South Dakota	86	Tennessee	64	Texas	48
Georgia	81	Massachusetts	61	Maryland	47
South Carolina	81	Michigan	61	Montana	47
New Mexico	78	New Jersey	61	Delaware	46
Louisiana	77	Washington	60	Hawaii	45
Maine	77	Vermont	58	Illinois	44
Missouri	73	New Hampshire	55	District of Columbia	43
Arizona	72	Oregon	55	Indiana	41
Wisconsin	71	Virginia	55	Idaho	39
California	70	Connecticut	54	Utah	35
Florida	70	Pennsylvania	54	Nevada	34
North Dakota	68	Ohio	53	Minnesota	33
Alabama	66	Kansas	52	Wyoming	23
Kentucky	66	Colorado	49	Alaska	21
				United States[2]	57

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[1] Rate per 100,000 workers insured in event disability.

[2] State average.

TABLE 76.—*Disability rates by diagnosis and by State*

State	Rate [1]	State	Rate	State	Rate
INFECTIVE AND PARASITIC (000–136)					
Alabama	26	Pennsylvania	13	Rhode Island	8
Arkansas	25	Delaware	12	South Dakota	8
Louisiana	25	Indiana	12	Utah	8
Mississippi	22	Arizona	11	Connecticut	7
Kentucky	20	Massachusetts	11	Idaho	7
Florida	19	Missouri	11	New Mexico	7
West Virginia	19	Ohio	11	Alaska	6
South Carolina	17	Oklahoma	11	Colorado	6
Georgia	15	Hawaii	10	Kansas	6
New Jersey	14	Maine	10	Nebraska	6
North Carolina	14	Oregon	10	Wisconsin	6
Tennessee	14	Texas	10	Minnesota	5
Virginia	14	District of Columbia	9	New Hampshire	5
Washington	14	Michigan	9	Nevada	4
California	13	Montana	9	Iowa	3
Illinois	13	New York	9	North Dakota	3
Maryland	13	Vermont	9	Wyoming	3
				United States [2]	11
NEOPLASMS (140–239)					
Arkansas	81	Texas	59	Delaware	51
Mississippi	81	Idaho	58	New Mexico	51
Alabama	73	New Jersey	58	Oregon	51
Florida	72	Vermont	58	Washington	51
Oklahoma	67	Louisiana	57	Indiana	50
South Carolina	66	Massachusetts	57	Pennsylvania	50
Kentucky	64	Nevada	57	Iowa	49
West Virginia	64	North Carolina	56	Tennessee	49
California	63	Arizona	54	Virginia	49
Kansas	63	Illinois	54	Ohio	47
Rhode Island	61	Maryland	54	Colorado	45
South Dakota	61	Montana	54	Minnesota	45
Michigan	60	Nebraska	54	Hawaii	43
Wisconsin	60	North Dakota	54	Wyoming	39
Georgia	59	New Hampshire	53	District of Columbia	37
Maine	59	New York	53	Utah	35
Missouri	59	Connecticut	51	Alaska	19
				United States [2]	53
ENDOCRINE, NUTRITIONAL, AND METABOLIC (240–279)					
Mississippi	39	Rhode Island	23	New Hampshire	19
West Virginia	36	South Carolina	23	Colorado	18
Georgia	34	Alabama	22	Delaware	18
District of Columbia	33	Nebraska	22	Kentucky	18
New Mexico	33	New York	22	Washington	18
Florida	28	Ohio	22	Arizona	17
Michigan	28	Oklahoma	22	Massachusetts	17
California	27	Pennsylvania	22	Iowa	15
Montana	27	Tennessee	22	Minnesota	15
Vermont	26	South Dakota	21	Utah	15
Arkansas	25	Texas	21	Kansas	14
Maine	25	Idaho	20	Oregon	14
Missouri	25	Illinois	20	Maryland	13
Nevada	25	Indiana	20	Virginia	13
New Jersey	24	North Dakota	20	Hawaii	11
Louisiana	23	Wisconsin	20	Alaska	9
North Carolina	23	Connecticut	19	Wyoming	7
				United States [2]	21

See footnotes at end of table.

TABLE 76.—*Disability rates by diagnosis and by State*—Continued

State	Rate [1]	State	Rate	State	Rate
NERVOUS SYSTEM AND SENSE ORGANS (320–389)					
Arkansas	69	Missouri	40	New Jersey	33
Mississippi	60	Ohio	40	Arizona	32
Louisiana	53	Michigan	39	Illinois	32
Montana	53	Indiana	38	Texas	32
New Mexico	50	Massachusetts	38	Utah	32
Idaho	49	South Dakota	38	Virginia	32
Rhode Island	49	Colorado	37	Georgia	31
West Virginia	49	South Carolina	37	Minnesota	31
Kentucky	48	Kansas	36	Wisconsin	31
Nevada	47	North Carolina	36	Connecticut	30
Florida	46	Tennessee	36	Vermont	30
Oklahoma	44	Iowa	34	Alaska	29
Alabama	43	New Hampshire	34	Hawaii	29
California	43	New York	34	North Dakota	29
Maine	43	Pennsylvania	34	Maryland	26
Delaware	41	Washington	34	Nebraska	26
Oregon	41	District of Columbia	33	Wyoming	25
				United States [2]	35
RESPIRATORY SYSTEM (460–519)					
West Virginia	214	Missouri	52	South Dakota	36
Kentucky	93	Washington	52	North Carolina	35
Arkansas	84	Colorado	50	North Dakota	35
Maine	75	Nevada	47	Delaware	34
New Mexico	74	California	46	Massachusetts	32
Arizona	64	Florida	46	Maryland	30
Mississippi	63	Wyoming	46	New Jersey	30
Montana	63	Ohio	45	Illinois	29
Alabama	60	Oklahoma	45	Rhode Island	28
Oregon	58	Michigan	43	New York	27
Vermont	58	Iowa	42	Wisconsin	26
Idaho	57	Indiana	40	Nebraska	25
South Carolina	56	Kansas	37	Minnesota	23
Tennessee	56	New Hampshire	37	Connecticut	22
Louisiana	55	Texas	37	Hawaii	20
Virginia	54	Utah	37	Alaska	19
Pennsylvania	53	Georgia	36	District of Columbia	18
				United States [2]	40
DIGESTIVE SYSTEM (520–577)					
West Virginia	28	Arizona	16	Illinois	13
Maine	25	Connecticut	16	New Hampshire	13
Florida	23	Missouri	16	South Dakota	13
New Mexico	23	Nevada	16	Vermont	13
California	22	North Carolina	16	Washington	13
Louisiana	21	Ohio	16	Iowa	12
Alabama	20	Oklahoma	16	Indiana	11
New York	20	District of Columbia	15	Kansas	11
Mississippi	19	Maryland	15	Montana	11
South Carolina	19	Michigan	15	Oregon	11
Tennessee	19	Pennsylvania	15	Hawaii	10
Arkansas	18	Colorado	14	North Dakota	10
Kentucky	18	Massachusetts	14	Wyoming	10
Rhode Island	18	Texas	14	Minnesota	8
Georgia	17	Wisconsin	14	Nebraska	7
New Jersey	17	Delaware	13	Utah	7
Virginia	17	Idaho	13	Alaska	4
				United States [2]	16

See footnotes at end of table.

TABLE 76.—*Disability rates by diagnosis and by State*—Continued

State	Rate [1]	State	Rate	State	Rate
MUSCULOSKELETAL SYSTEM (710–738)					
Arkansas	205	Utah	103	Delaware	76
New Mexico	196	Washington	101	New Jersey	74
Mississippi	167	Georgia	99	Pennsylvania	74
Louisiana	163	Kentucky	99	Minnesota	73
California	158	Vermont	99	Hawaii	71
Idaho	157	Michigan	97	New York	68
West Virginia	152	South Dakota	95	North Carolina	67
Oregon	151	Colorado	93	Illinois	66
Alabama	139	South Carolina	93	Kansas	65
Montana	138	Ohio	86	Wyoming	64
Nevada	131	Wisconsin	83	District of Columbia	63
Oklahoma	125	Iowa	82	Nebraska	63
Tennessee	113	Missouri	82	New Hampshire	61
Florida	111	Virginia	81	Connecticut	60
Arizona	109	Indiana	79	North Dakota	55
Maine	109	Massachusetts	79	Maryland	53
Rhode Island	107	Texas	77	Alaska	42
				United States [2]	89
ACCIDENTS (800–999)					
West Virginia	88	Wyoming	49	Maryland	37
Oregon	85	North Carolina	48	Pennsylvania	37
Louisiana	83	South Dakota	48	Rhode Island	37
New Mexico	80	Oklahoma	47	Wisconsin	37
Mississippi	79	South Carolina	47	Kansas	36
Arkansas	77	Vermont	47	Iowa	33
Idaho	75	Michigan	46	New Jersey	33
Alabama	69	Virginia	46	New York	32
Washington	69	District of Columbia	45	Utah	32
Nevada	65	Florida	45	Connecticut	31
California	64	Arizona	43	Hawaii	31
Montana	59	Maine	42	New Hampshire	31
Colorado	57	Missouri	40	Minnesota	29
Georgia	52	Ohio	40	North Dakota	28
Texas	52	Delaware	38	Nebraska	27
Kentucky	51	Massachusetts	38	Illinois	26
Tennessee	50	Indiana	37	Alaska	21
				United States [2]	69

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[1] Rate per 100,000 workers insured in event of disability.

[2] State average.

TABLE 77.—*Disability rates by diagnosis and by State*

State	Rate [1]	State	Rate	State	Rate
ISCHEMIC HEART (410–414)					
Arkansas	222	Idaho	123	Wisconsin	103
Mississippi	220	Georgia	121	New Hampshire	96
West Virginia	203	Missouri	120	Arizona	95
Louisiana	197	Maryland	119	North Dakota	93
South Carolina	195	Michigan	119	Kansas	91
Alabama	192	Delaware	116	Illinois	87
Kentucky	161	Oregon	114	Connecticut	85
Florida	157	Washington	114	Nevada	83
Maine	152	Rhode Island	113	New Mexico	83
Tennessee	151	Vermont	113	Wyoming	81
Virginia	143	New York	110	District of Columbia	78
Ohio	134	Texas	110	Utah	68
Pennsylvania	131	South Dakota	109	Minnesota	67
North Carolina	130	Massachusetts	108	Hawaii	65
New Jersey	129	Montana	108	Nebraska	62
California	127	Indiana	105	Colorado	57
Oklahoma	126	Iowa	104	Alaska	42
				United States [2]	114
ARTHRITIS (710–718)					
Arkansas	98	South Carolina	61	District of Columbia	40
New Mexico	97	Washington	61	North Carolina	40
Alabama	83	Utah	60	Wyoming	40
Mississippi	82	Virginia	53	Kansas	39
West Virginia	82	Wisconsin	52	Massachusetts	38
Idaho	81	Georgia	50	New Jersey	38
Oklahoma	78	Iowa	50	New York	38
California	74	Ohio	49	Delaware	37
Oregon	74	Colorado	48	Illinois	37
Arizona	71	Michigan	47	Minnesota	37
Louisiana	70	Kentucky	45	Nebraska	35
Montana	67	Nevada	45	Connecticut	33
Tennessee	65	Indiana	44	New Hampshire	30
Maine	64	Texas	44	North Dakota	30
Vermont	64	South Carolina	43	Maryland	27
Florida	62	Missouri	42	Alaska	25
South Dakota	62	Pennsylvania	42	Hawaii	22
				United States [2]	47
PSYCHOSES (290–299)					
Mississippi	55	Michigan	32	Washington	24
Georgia	46	New Jersey	32	Arizona	23
Maine	46	Rhode Island	31	Texas	23
South Dakota	42	Iowa	30	Colorado	22
New Mexico	41	Connecticut	29	Illinois	22
Arkansas	38	North Dakota	29	Nebraska	22
California	38	Pennsylvania	29	Ohio	22
Louisiana	38	Vermont	29	Tennessee	22
South Carolina	38	Hawaii	28	North Carolina	20
Florida	37	Kansas	28	Minnesota	19
Wisconsin	37	Maryland	27	Indiana	18
Massachusetts	34	New Hampshire	27	Montana	18
Alabama	33	Delaware	26	Utah	18
Missouri	33	Virginia	26	Nevada	17
New York	33	Oregon	25	Idaho	15
West Virginia	33	District of Columbia	24	Alaska	12
Kentucky	32	Oklahoma	24	Wyoming	12
				United States [2]	30

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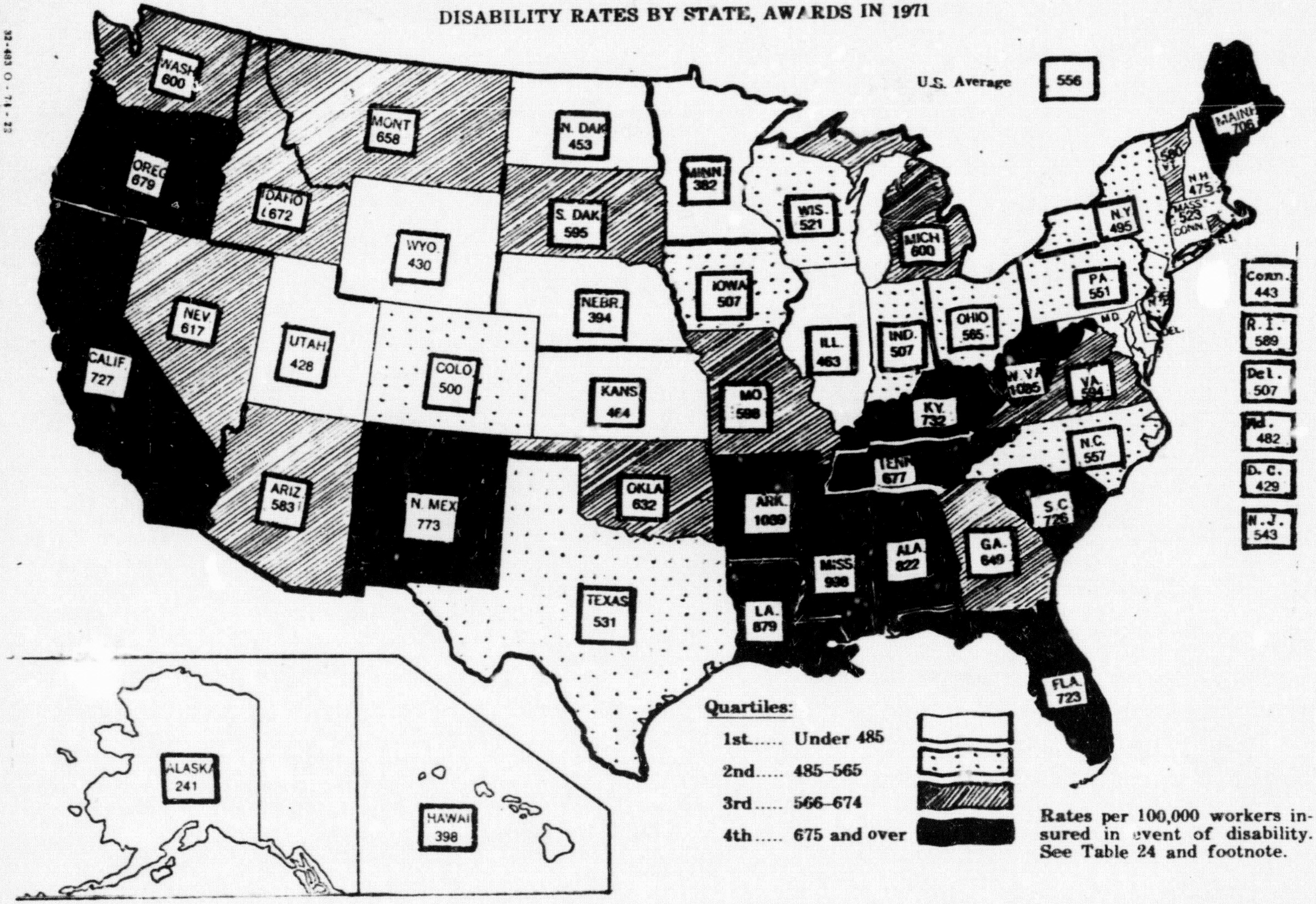
[1] Rate per 100,000 workers insured in event of disability.

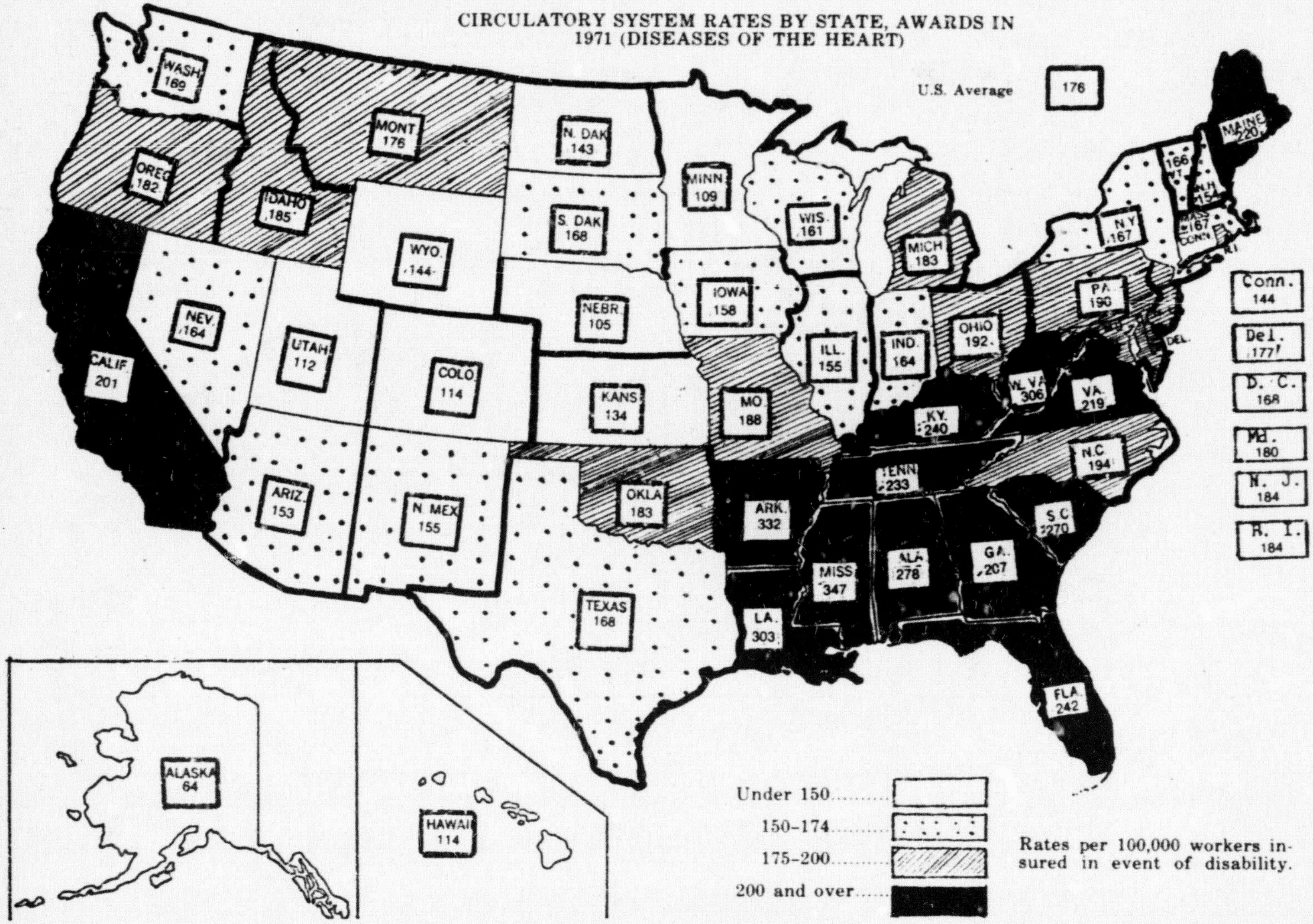
[2] State average.

DISABILITY RATES BY STATE, AWARDS IN 1971


U.S. Average 556
WASH 600
MONT 658
N. DAK 453
MINN 382
OREG 679
IDAHO 672
WYO 430
S. DAK 595
WIS. 521
MICH 600
MAINE 706
VT 580
N.H 475
MASS 523
CONN
R.I.
N.Y 495
NEV 617
UTAH 428
COLO 500
NEBR. 394
IOWA 507
ILL. 463
IND. 507
OHIO 565
PA 551
N.J.
MD
DEL.
CALIF. 727
KANS 464
MO. 588
KY. 732
W. VA 1085
VA. 594
N.C. 557
ARIZ. 583
N. MEX 773
OKLA 632
ARK. 1089
TENN 677
S.C 726
GA. 649
ALA. 822
MISS 998
LA. 879
TEXAS 531
FLA. 723
Conn. 443
R.I. 589
Del. 507
Md. 482
D.C. 429
N.J. 543
ALASKA 241
HAWAII 398
Quartiles:
1st..... Under 485
2nd..... 485–565
3rd..... 566–674
4th..... 675 and over

Rates per 100,000 workers insured in event of disability. See Table 24 and footnote.

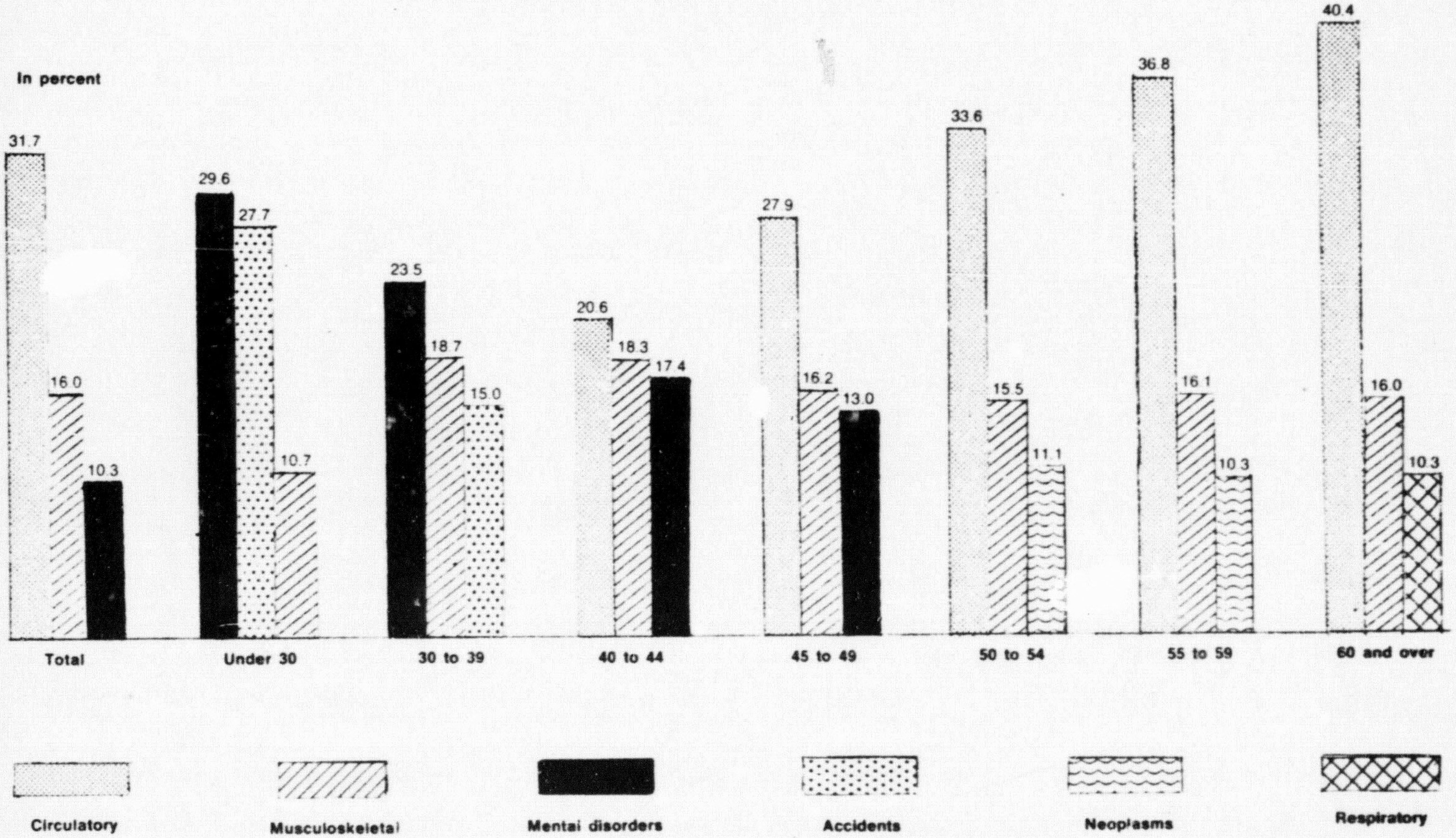
CIRCULATORY SYSTEM RATES BY STATE, AWARDS IN 1971 (DISEASES OF THE HEART)


U.S. Average 176
WASH. 169
OREG. 182
CALIF. 201
IDAHO 185
NEV. 164
MONT. 176
WYO. 144
UTAH 112
ARIZ. 153
COLO. 114
N. MEX. 155
N. DAK. 143
S. DAK. 168
NEBR. 105
KANS. 134
OKLA. 183
TEXAS 168
MINN. 109
IOWA 158
MO. 188
ARK. 332
LA. 303
WIS. 161
ILL. 155
MISS. 347
MICH. 183
IND. 164
KY. 240
TENN. 233
ALA. 278
OHIO 192
W. VA. 306
VA. 219
N.C. 194
S.C. 270
GA. 207
FLA. 242
PA. 190
N.Y. 167
VT. 166
N.H. 154
MAINE 220
MASS. 167
CONN.
R.I.
DEL.
Conn. 144
Del. 177
D. C. 168
Md. 180
N. J. 184
R. I. 184
ALASKA 64
HAWAII 114
Under 150
150–174
175–200
200 and over

Rates per 100,000 workers insured in event of disability.

DISABLED WORKER AWARDS

Leading Diagnostic Groups by Age, 1971



6. Cost Estimates on Disability Program—Selected Materials

A. ADVERSE COST EXPERIENCE

Staff question: ***Do you have any preliminary report or information on the Social Security Administration's study of the recent increases in disability rates?***

We have been examining data for the purpose of looking into what factors could have contributed to the increase in disability awards in recent years. Our opinions on the reasons for the increase in awards are substantially the same now as when we first started studying this problem.

Specifically, examination of the recent increases in disability awards has been directed into four areas of study: (1) Relationship between unemployment and disability insurance application; (2) reconsideration and appeals; (3) cohort follow-up over time; and (4) disability allowance incidence rates. Study of the most recently available data in the first two areas is nearing completion. The cohort follow-up project is a long-range study, with some data soon to be available. This project is expected to draw most of its data from a longitudinal sample of disability applicants maintained by the Division of Disability Studies, ORS. The sample has experienced processing delays in the past several months, but is now operational so work can now proceed on the cohort study. OACT is developing disability allowance incidence rates (item 4) and the results are expected in the next few months.

Preliminary analysis appears to indicate that there is a positive relationship between the unemployment rate and the number of applications filed for disability insurance, and that the number of awards is a function of the amount of applications received. Since economic conditions in the United States at the present time will probably lead to an increase in the unemployment rate, we might expect the number of awards in the near future to further increase. Economic models taking this economic and other factors into consideration will be included in a later report.

In addition to the unemployment rate, changes in the number of reconsideration and hearing allowances also have contributed to the increase in awards. The number of disability awards in a given year are essentially the sum of initial allowances, reconsideration allowances, and reversals of prior denials at the hearing level. The data supplied by BDI show that initial allowance rates have decreased since 1969, and are at present about 42 percent. However, receipts increased considerably after 1970. This increase in applications, even though the allowance rate has not increased, causes an increase in the number of initial allowances. Reconsideration allowances, however, have increased considerably in the past few years, from 32,000 in 1970 to 62,000 in 1973. Likewise, allowances at the hearing level in the 1970's were quite a bit higher than in the 1960's, e.g., 24,000 allowances in 1973 versus 10,000 in 1969. While this higher rate of increases in the appeals process does not, of course, completely explain the total increases experienced in recent years, we feel that these increases do contribute substantially to the total increase.

Another factor which probably contributes to the increase in DIB applications and hence awards, is public awareness of the disability program in general. While we have no direct way at the moment of measuring this, it is our opinion that the disability program has not reached maturity to the degree experienced in the retirement and survivors program. Public awareness is probably increasing through our public information efforts and those of social services organizations, labor unions, etc. In addition, implementation of the SSI program has resulted, to some degree, in publicizing the disability program. How much all this would contribute to the increase is not measurable, but results from our 1972 and 1974 surverys should shed some light in this area.

It is apparent that a variety of factors are responsible for the increase in disability awards, the most important being the ones we have outlined above. It would also appear that, at least for the near future, the number of disability awards will continue to increase. It would appear then that the DI long-range cost estimates should reflect the most recent awards experience for 1972–74, and that future cost estimates should be revised as data becomes available. In the meantime, we will continue to examine the disability data to develop a better understanding of the Allowance-Award trends.

Staff question: ***Since 1967 the disability insurance system has increased in cost from 0.96 percent of payroll (the estimate made in 1969) to an estimated cost of 1.58 percent of payroll at the time of the 1973 Amendments. Of this increase in cost, how much is due to liberalizations of benefits and eligibility requirements, and how much is based on revision of the estimate due to adverse experience?***

We believe that the change in the long-range cost of the DI program since 1969 could be summarized in the following table.

Long-range cost as percent of payroll

Item	*Percent*
Cost of the 1967 act as estimated in 1969	0.96
Liberalizations enacted in 1969–73	.42
Changes in experience incorporated in cost estimates in 1969–73	.29
Changes in taxable earnings base enacted in 1969–73	-.11
Changes in actuarial procedures and economic assumptions in 1969–73	.02
Total change in the cost of the program	.62
Cost of the 1973 act as estimated in 1973	1.58

In the preparation of the above table it has been assumed that a portion of the benefit increases included in the 1969 and 1971 Amendments are not "liberalization" since cost estimates prepared before 1972 were on a level-earnings basis, which implicitly assume that benefits would be increased as the level of earnings increased. It has also been assumed that the effect of the change from level-earnings assumptions to dynamic assumption in 1972 can be grouped with the further modification in the dynamic assumptions used after 1972.

STAFF NOTE.—Later information in the 1974 Trustees Report (H. Doc. 93-313) indicates that about 0.32 percent of payroll should be added to the above-cited costs—0.21 percent of the additional cost is attributed to higher awards level while the balance is the results in changes in the economic and demographic assumptions.

TABLE 78.—*Change in old-age, survivors, and disability insurance long-range actuarial balance,[1] as percent of taxable payroll,[2] by type of assumption*

[In percent of taxable payroll]

	Old-age and survivors insurance	Disability insurance	Total
Actuarial balance under previous estimates	-0.43	-0.08	-0.51
Retirement rates	-0.14		-0.14
Disability rates		-.21	-.21
Population assumptions	-1.79	-.08	-1.87
Economic assumptions	-.18	-.01	-.19
All other factors (net)	-.04	-.02	-.06
Change in actuarial balance	-2.15	-.32	-2.47
New actuarial balance	-2.58	-.40	-2.98

[1] Represents the difference over the 75-year period, 1974–2048, between the average tax rate and the average cost.

[2] Payroll is adjusted to take into account the lower contribution rate on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

Source: 1974 Trustees Report, p. 36.

TABLE 79.—*Estimated actuarial balance*[1] *of old-age, survivors, and disability insurance system as percent of taxable payroll,*[2] *dynamic assumptions*[3]

[In percent]

Item	OASI	DI	Total
Average-cost of system	11.97	1.92	13.89
Average rate in present tax schedule	9.39	1.52	10.91
Actuarial balance	−2.58	−.40	−2.98

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[1] As measured over the 75-year period, 1974–2048.

[2] Payroll is adjusted to take into account the lower contribution rates on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

[3] See text for a description of the assumptions.

Source: 1974 Trustees Report, p. 35.

TABLE 80.—*Estimated "current-cost"*[1] *of old-age, survivors, and disability insurance system as percent of taxable payroll*[2] *under dynamic assumptions,*[3] *for selected years, 1985–2045*

[In percent]

Calendar year	Old-age and survivors insurance	Disability insurance	Total
1985	9.00	1.44	10.44
1990	9.52	1.51	11.03
1995	9.64	1.61	11.25
2000	9.54	1.77	11.31
2005	9.72	1.97	11.69
2010	10.56	2.13	12.69
2015	11.82	2.22	14.14
2020	13.47	2.24	15.71
2025	14.78	2.19	16.97
2030	15.46	2.14	17.60
2035	15.49	2.19	17.68
2040	15.40	2.28	17.68
2045	15.53	2.33	17.86
Average cost[4]	11.97	1.92	13.89

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[1] Represents the cost as percent of taxable payroll of all expenditures in the year, including amounts needed to maintain the funds at about one year's expenditures.

[2] Payroll is adjusted to take into account the lower contribution rate on self-employment income, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.

[3] See text for a discription of the assumptions.

[4] Represents the arithmetic average of the "current-cost" for the 75-year period 1974–2048.

Source: 1974 Trustees Report, p. 37.

B. BASIC COST ASSUMPTIONS

BASIC ASSUMPTIONS USED IN PROJECTING DISABLED-WORKER BENEFICIARIES FOR LONG-RANGE ACTUARIAL COST ESTIMATES, AND ANALYSIS OF RECENT EXPERIENCE

(By Francisco Bayo, Deputy Chief Actuary, Social Security Administration)

Projections of disabled-worker beneficiaries used in long-range actuarial cost estimates are prepared by following three basic steps. The first step is to project the population insured for disability benefits. This projection, which is prepared by age and sex, is based on the projection of the population of the United States underlying all of OASDHI cost estimates. The method consists of subdividing the projected adult population under age 65 into those who are insured for disability benefits and those who are not. That subdivision reflects the actual experience under the DI program as well as the projected labor-force participation rates.

The second step is to project the incidences of disability among the insured workers. These incidences are calculated by age and sex as the product of the projected insured population by the estimated disability incidence rates. These rates are based on disabled-worker benefits awarded through the end of calendar year 1973 and reflect only those levels of incidence experienced under the DI program as of that point in time. No attempt is made to project possible future increases or decreases in those levels although recent experience has shown an increasing trend.

The final step is to calculate the number of persons receiving disabled-worker benefits in future years. This is accomplished by the addition of the incidences and the subtraction of termination which can result from death, recovery from the disability, or attainment of age 65. The latest projection is based on the actual rates of benefit termination experienced under the Disability Insurance program during 1957–66.

One item mentioned in passing in the above overview, namely the increasing trend in the levels of disability incidences, warrants elaboration. An analysis of that experience as reflected by the disabled-worker awards is summarized in the following table:

TABLE 81.—*Comparison of disabled-worker awards, experienced and expected awards, 1965–73*

[In thousands]

	Disabled-worker awards			Ratio adjusted to expected
	Actual	Adjusted [1]	Expected [2]	
(1)	(2)	(3)	(4)	(5)
Calendar year:				
1965	254	266	272	0.98
1966	278	292	285	1.02
1967	301	316	291	1.09
1968	323	325	298	1.09
1969	345	345	303	1.14
1970	350	450	310	1.13
1971	416	416	315	1.32
1972	457	457	322	1.42
1973	492	492	328	1.50

[1] Computed as the actual awards plus an adjustment to include the additional awards that would have been made if the 1967 act had been in effect throughout the entire period.

[2] The expected awards are based on the estimated ultimate rates experienced by age and sex in calendar year 1965, and on the insured population estimated as if the 1967 act had been in effect throughout the entire period.

This analysis is based on an estimate of the number of awards that would have been made in the years 1965–73 if the estimated ultimate disability rates by age and sex for 1965 had been experienced throughout the period. This does not mean that the 1965 experience should be expected to be repeated every year. The purpose is to place all years on the same "common ground" so that trends can be detected more readily.

It can be observed from the table that the actual awards made in 1973 were 150 percent of the awards that would have been expected if the 1965 rates had been in effect. This means that after adjusting for age and sex differences, as well as for the increasing number of insured workers, the average disability award rate in 1973 was about 50 percent higher than in 1965.

The last column in the table indicates that the actual average award rate increased slowly (at about 3 percent per year) during the late 1960's and then accelerated significantly after 1970 (to about 12 percent per year).

In my opinion the present financing of the Disability Insurance program should take into account the full effect of the increases in the disability award rates that have been experienced through calendar year 1973. Future increases or decreases in the award rates experience should be recognized as they occur in further modifications of the financing.

In order to properly finance the Disability Insurance program the resulting levels which have been attained through calendar year 1973 must be taken into account. However, future variations in the award rates need not be anticipated at this time but can instead be reflected by modifying the financing scheme as they occur.

TABLE 82.—*Number of disabled-worker beneficiaries in current-payment status per 1,000 insured workers beginning of year, 1967–74*

	Estimated number of workers (millions)	Number of beneficiaries (thousands)	Number of beneficiaries per 1,000 insured workers
Year:			
1967	55. 7	1,097. 2	19. 7
1968	56. 9	1,193. 6	21. 0
1969	70. 1	1,295. 4	18. 5
1970	72. 4	1,394. 5	19. 3
1971	74. 5	1,493. 3	20. 0
1972	76. 1	1,647. 7	21. 6
1973	77. 7	1,823. 7	23. 5
1974	[1] 79. 4	2,016. 9	25. 4

[1] Preliminary estimate.

TABLE 83.— *Disabled-worker benefits, number in force and number terminated because of recovery, 1957–72*

	Disabled worker benefits in force [1]	Benefits terminated because of recovery	Termination as percent of benefits in force
Year: [2]			
1957	178, 802	52	([3])
1958	294, 153	1, 397	0. 5
1959	419, 015	3, 228	. 8
1960	544, 838	3, 124	. 6
1961	735, 506	2, 936	. 4
1962	870, 594	9, 555	1. 1
1963	966, 034	12, 931	1. 3
1964	1, 035, 776	16, 487	1. 6
1965	1, 150, 699	18, 441	1. 6
1966	1, 272, 396	23, 111	1. 8
1967	1, 405, 125	37, 151	2. 6
1968	1, 521, 580	37, 723	2. 5
1969	1, 644, 124	38, 108	2. 3
1970	1, 761, 138	40, 802	2. 3
1971	1, 926, 359	42, 981	2. 2
1972	2, 105, 422	39, 393	1. 9

[1] Include end-of-year in force plus beneficiaries terminated during the year for any reason.

[2] Monthly cash benefits first payable to disabled workers aged 50–64 in July 1957. Workers under age 50 became eligible for benefits in November 1960.

[3] Less than 0.05 percent.

C. MORTALITY EXPERIENCE

DECLINING MORTALITY AMONG DISABLED-WORKER BENEFICIARIES

(By Charles M. Croner and Lawrence D. Haber, Division of Disability Studies. Research and Statistics Note No. 13, May 14, 1974)

Data on death rates for disabled-worker beneficiaries under the social security program and for similar age groups in the U.S. population show that mortality levels for disabled-worker beneficiaries—both men and women—declined from 1966 through 1971 but were still at a point well above those of the total population. Death rates for the total population, however, remained relatively stable. Comparison of the data in tables 84 and 85 suggests that the decline in death rates among the disabled-worker beneficiaries is, in part, a function of changes in the composition of the program rather than changes in population mortality trends. This may help to explain the slackening in benefit terminations in relation to the number of disabled-worker beneficiaries in current-payment status.

Programmatic changes having particular bearing on the period studied include the Social Security Amendments of 1965 and 1967. The 1965 amendments reduce the disability duration requirements to "at least 12 months," in place of the earlier requirement that the physical or mental impairment be of permanent or indefinite duration.[1] The change in eligibility requirements appears to have brought disabled workers onto the beneficiary rolls, since 1965 with better survival expectations than earlier beneficiaries.

The 1967 provisions extend the alternative insured status for certain workers disabled before age 31 to all workers disabled before that age regardless of the nature of the disability.[2] Consequently, the number of insured disabled workers under age 31 nearly doubled in 1969.

Examination of the data shows that disabled-worker beneficiaries at all ages had considerably higher death rates than corresponding age groups in the U.S. population.[3] The differences were most pronounced, however, among the youthful components of the two populations—those under age 35. At that age level, the death rates for disabled-worker beneficiaries were more than 10 times higher than the rates for the U.S. population. The difference in rates was especially large for women.

After age 45 the ratio of difference in death rates between the disabled-worker beneficiary and U.S. populations narrowed appreciably toward the latter part of the life cycle as a result of comparatively sharper increases in mortality among older persons in the U.S. population. Nevertheless, among men aged 55–64, the death rate for disabled-worker beneficiaries was nearly four times that of the U.S. population in 1971. The death rate for the entire disabled-worker beneficiary population in 1971 was roughly equivalent to that for 75-year-old men in the U.S. population.

Finally, death rates among women disabled-worker beneficiaries over age 45 showed a marked tendency to stabilize throughout the period studied. By comparison, death rates for their male counterparts, and for men and women of the same age bracket of the U.S. population, continued to increase with advancing age. Although the differences in primary diagnoses for disabled men and women suggest that there are causes for differential rates of mortality,[4] the data available at this point are inadequate to determine the relationships between primary disabling conditions and death rates.

The following table shows age-adjusted death rates[5] for men and women disabled-worker beneficiaries. These rates were relatively constant or stable during the period 1966–69. From 1969 to 1971, however, age-adjusted death rates for both men and women declined abruptly, apparently reflecting some change in the character or composition of the beneficiary population. The death rate for all age groups, in fact, declined substantially during this 2-year period.

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[1] "History of the Provisions of Old-Age, Survivors, Disability, and Health Insurance," DHEW Pub. No. (SSA) 72–11501, Office of the Actuary, Social Security Administration, Washington, D.C., June 1971.

[2] Wilbur J. Cohen and Robert M. Ball, "Social Security Amendments of 1967: Summary and Legislative History," *Social Security Bulletin*, vol. 31, no. 2, February 1968.

[3] Slight changes in these estimates of death rates can be anticipated as a result of lags in the reporting of deaths; however, these changes should have no significant effect on the estimates.

[4] Respiratory disorders, for example, tend to affect substantially more men than women in the total disabled population (ages 45–64) and in the disabled-worker beneficiary population of all ages. See Lawrence D. Haber, "Disabling Effects of Chronic Disease and Impairment," *Journal of Chronic Diseases*, vol. 24, 1971, p. 473, and Phoebe H. Goff, "Disabled Beneficiary Population, 1957–66, "*Social Seccrity Bulletin*, July 1971, pp. 1–11.

[5] Based on the distribution of the population aged 25–64 enumerated in 1970.

TABLE 84.—*Age-adjusted death rates for men and women disabled-worker beneficiaries*

	Age-adjusted rate per 1,000 population [1]	
	Men	Women
Year:		
1971	48. 8	39. 6
1970	52. 2	42. 7
1969	58. 0	46. 1
1968	55. 6	47. 2
1967	57. 4	47. 6
1966	57. 2	47. 7
1965	60. 5	51. 7
1964	63. 1	56. 5
1963	65. 2	57. 2
1962	66. 8	58. 5

[1] Age-adjusted rates were computed by the direct method, applying the age-specific death rates for men and women disabled-worker beneficiaries aged 25 to 64 to the standard population distributed by age. The total population aged 25 to 64 as enumerated in 1970 was selected as the standard.

It appears from this examination that death rates for disabled-worker beneficiaries during the period 1966–71 were affected only slightly by changes in the age structure of the beneficiary population and largely by other changes in the composition of the beneficiary population. Declining death rates appear to reflect primarily the changes in social security legislation affecting the eligibility of beneficiaries; there were no major changes in overall mortality trends during the period studied.

TABLE 85.—*Disabled-worker death rates: Number of deaths per 1,000 disability beneficiaries, by sex, 1966–71* [1]

Age	Men						Women					
	1966	1967	1968	1969	1970	1971	1966	1967	1968	1969	1970	1971
Total	75.0	75.2	74.6	75.8	69.0	64.8	54.3	54.0	54.0	53.1	52.0	46.7
Under 25 [2]	29.5	50.9	25.4	12.7	26.2	24.4	63.8	30.0	39.1	26.0	33.1	36.6
25 to 29	43.7	42.0	35.0	37.5	30.7	29.7	42.9	39.4	38.4	34.9	34.3	29.9
30 to 34	34.7	37.4	35.3	37.7	33.5	31.0	36.4	38.1	38.1	42.1	32.6	30.3
35 to 39	39.5	38.8	36.9	40.5	38.5	34.2	37.4	41.8	38.4	37.8	37.7	33.7
40 to 44	47.1	48.1	48.1	51.2	45.4	42.3	45.0	44.1	46.3	41.7	37.9	36.6
45 to 49	59.7	60.2	59.5	61.4	56.3	52.4	54.4	54.8	52.2	50.5	47.0	45.1
50 to 54	75.1	75.5	73.0	75.8	67.9	63.4	56.8	56.2	55.8	55.9	50.9	47.0
55 to 59	83.5	83.9	83.7	84.3	78.3	72.7	57.1	55.6	57.0	55.6	52.6	49.8
60 to 64	88.1	87.5	89.1	90.3	81.7	78.2	55.3	55.4	55.5	55.5	51.3	49.3

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[1] Includes all disabled workers with benefits in current-payment status at end of year and disabled workers whose benefits were terminated during year because of death.

[2] Disabled workers under age 25 form a very small portion of those with benefits in current-payment status at end of year. In 1971, for example, men and women in this age group comprised about 1 percent of all disabled beneficiaries.

TABLE 86.—*Total U.S. population aged 15 to 64: Number of deaths per 1,000, by sex, 1966–71*

Age	Men						Women					
	1966	1967	1968	[1]1969	[1]1970	[1]1971	1966	1967	1968	[1]1969	[1]1970	[1]1971
Total	6.7	6.6	6.8	6.7	6.7	6.5	3.5	3.5	3.6	3.5	3.5	3.4
15 to 19	1.5	1.5	1.6	1.6	1.6	1.6	.6	.6	.6	.6	.6	.6
20 to 24	2.0	2.0	2.2	2.3	2.3	2.2	.7	.7	.7	.7	.7	.7
25 to 29	1.9	1.9	2.0	2.1	2.0	2.0	.9	.8	.9	.9	.9	.9
30 to 34	2.2	2.2	2.3	2.3	2.3	2.2	1.3	1.2	1.2	1.2	1.2	1.2
35 to 39	3.1	3.1	3.2	3.2	3.1	3.1	1.8	1.9	1.9	1.9	1.8	1.8
40 to 44	4.7	4.7	4.9	4.9	4.8	4.7	2.8	2.7	2.9	2.8	2.7	2.8
45 to 49	7.5	7.5	7.7	7.6	7.6	7.3	4.2	4.2	4.3	4.2	4.2	4.1
50 to 54	12.2	12.0	12.2	11.9	11.8	11.5	6.2	6.2	6.3	6.1	6.2	6.0
55 to 59	19.2	18.8	19.1	18.7	18.6	17.9	9.[illegible]	9.1	9.3	9.0	9.1	8.7
60 to 64	28.2	28.0	29.2	28.5	27.9	27.9	13.[illegible]	13.3	13.9	13.4	13.2	13.3

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[1] Department of Health, Education, and Welfare, Health Resources Administration, National Center for Health Statistics, "Summary Report—Final Mortality Statistics," *Monthly Vital Statistics Report, 1969*, Vol. 21, No. 4 (Supplement 2), July 25, 1972; *1970*, Vol. 22, No. 8, Nov. 14, 1973; *1971*, Vol. 22, No. 9, Dec. 4, 1973.

D. RESEARCH BY OFFICE OF RESEARCH AND STATISTICS

In response to a request for research materials on disability, particularly the cost estimates, the following materials were supplied to the staff.

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Social Security Survey of the Disabled: 1966, Report No. 23, March 1973, Income of OASDHI Beneficiaries and Other Disabled by Idella Swisher, DHEW-SSA-ORS.

Research and Statistics Note, DHEW-SSA-ORS, Identifying Disabled Workers Who May Return to Work: Rehabilitation and Medical Improvement Screening Decisions by Ralph Treitel.

Some Parameters for Social Policy in Disability: A Cross-National Comparison by Lawrence D. Haber, Milbank Memorial Fund Quarterly, Health and Society, Summer 1973.

Recovery and Benefit Termination: Program Experience of Disabled-Worker Beneficiaries by Jack Schmulowitz. Reprinted from the Social Security Bulletin, June 1973, DHEW-SSA.

Following receipt and perusal of this material the staff asked the Office of Research and Statistics the following question:

Staff question: ***Would you provide us with copies of Office of Research and Statistics studies (or designate the ones that have already been transmitted) which are directly relevant to the social security disability insurance cost estimates?***

Please state in some detail why the designated material is pertinent.

Most of the reports we previously submitted on research activity in the area of disability studies refer to descriptive cross-sectional surveys of the disabled, which indicate the extent of coverage of disability insurance programs according to self reports of persons surveyed. This information is useful for general estimates of what disabled groups have coverage, but cannot be used directly for costs of benefits or minute trends over time. The reports which best summarize the data from the surveys and which may be useful for any committee concerns of extensions of coverage to special groups, such as the older occupationally disabled, would include reports 3, 7, 19 and 23 from the 1966 Social Security Survey of Institutionalized Adults. A general overview of research problems and needs for policy concerns is presented in an article, "Some Parameters for Social Policy in Disability: A Cross-National Comparison," in *Health and Society*, Summer 1973, by Lawrence D. Haber.

In addition to the survey research, our Office of Research and Statistics reviews data on the demographic and disability characteristics of beneficiariesr These reports may be useful as general background information on the characteristics of new beneficiaries and those who leave the rolls as they change ovetime, but may not be useful for precise measures of change expected due to legislative amendment, since nonbeneficiaries are not included in program data. The most useful examples of kind of information would be data on awards and in-force benefits in the *Annual Statistical Supplement, Social Security Bulletin*. Special studies on characteristics of allowed and recovered beneficiaries would include the report in the September 1973 Bulletin, already reviewed by the Committee, "Disabled Worker Beneficiaries Under OASDI: Regional and State Patterns," the report on "Disabled Beneficiary Population" in the July 1971 Bulletin; and one on "Recovery and Benefit Termination" in the June 1973 Bulletin.

Staff question: ***Prepare a chart showing the number of social security (title II) disability applications filed over the last 10 years.***

E. DISABILITY APPLICATIONS

TABLE 87.—*Disabled worker applications, receipts in district offices by quarter and by fiscal year*

Fiscal year	Fiscal quarter				Fiscal year total
	July-September	October-December	January-March	April-June	
1962:					
Number	112, 808	102, 399	107, 967	116, 935	440, 109
Percent of previous quarter		90. 8	105. 4	108. 3	
1963:					
Number	113, 503	98, 642	117, 666	123, 056	452, 867
Percent of previous quarter	97. 1	86. 9	119. 3	104. 6	
Percent of previous year					102. 9
1964:					
Number	117, 682	101, 422	118, 926	121, 474	459, 504
Percent of previous quarter	95. 6	86. 2	117. 3	102. 1	
Percent of previous year					101. 5
1965:					
Number	116, 569	116, 106	121, 330	125, 414	479, 419
Percent of previous quarter	96. 0	99. 6	104. 5	103. 4	
Percent of previous year					104. 3
1966:					
Number	145, 767	136, 757	142, 631	139, 588	564, 743
Percent of previous quarter	116. 2	93. 8	104. 3	97. 9	
Percent of previous year					117. 8
1967:					
Number	136, 656	125, 629	143, 549	143, 262	549, 096
Percent of previous quarter	97. 9	91. 9	114. 3	99. 8	
Percent of previous year					97. 2
1968:					
Number	147, 688	138, 700	183, 064	186, 861	656, 313
Percent of previous quarter	103. 09	93. 9	132. 0	102. 1	
Percent of previous year					119. 5
1969:					
Number	184, 156	165, 690	180, 584	185, 785	716, 215
Percent of previous quarter	98. 6	90. 0	109. 0	102. 9	
Percent of previous year					109. 12
1970:					
Number	180, 824	177, 978	199, 292	221, 832	779, 926
Percent of previous quarter	97. 3	98. 1	112. 0	111. 3	
Percent of previous year					108. 9
1971:					
Number	231, 848	216, 866	233, 963	[1] 243, 404	[1] 926, 081
Percent of previous quarter	104. 5	93. 5	107. 9	104. 0	
Percent of previous year					118. 7
1972:					
Number	233, 473	213, 096	240, 718	237, 005	924, 292
Percent of previous quarter	95. 9	91. 3	112. 9	98. 5	
Percent of previous year					99. 8
1973:					
Number	241, 657	228, 075	268, 420	267, 000	1, 005, 152
Percent of previous quarter	102. 0	94. 4	117. 7	99. 5	
Percent of previous year					108. 7
1974:					
Number	273, 236	258, 833	361, 259		
Percent of previous quarter	102. 3	94. 7	139. 6		

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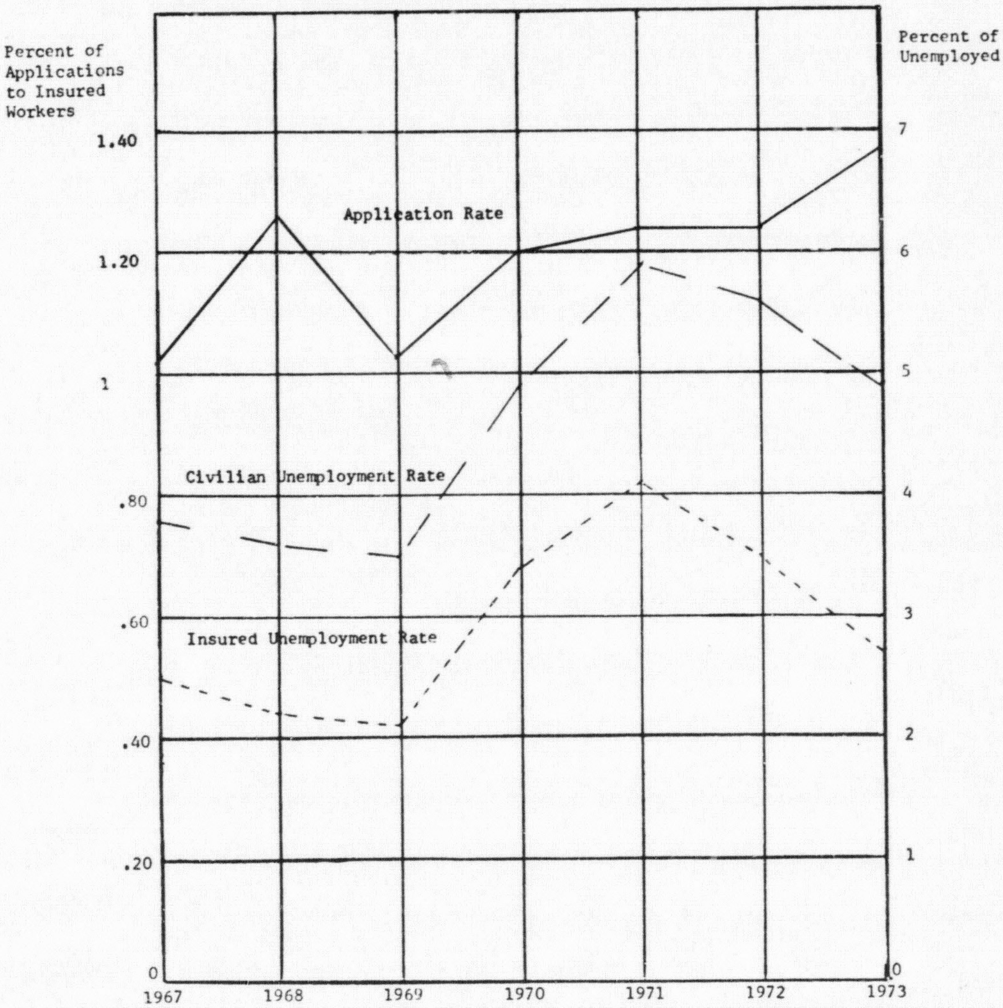
[1] 53d week omitted.

NOTE ON RECEIPTS OF DISABLED WORKER APPLICATIONS

Applications exceed eventual determinations by 5 to 10 percent because a determination is not required in certain situations—for example, if the claimant dies during the waiting period, or if the claim was filed after the claimant attained age 66, or if the claimant alleges disability began within 5 months of attainment of age 65 or the claimant files both an RSI claim and a disability freeze claim but the freeze would not affect the computation of benefits, or both DIB and RSI claims are filed but the claimant lacks DIB insured status (CM 6147).

The effect of legislation on the volume of receipts is apparent in the first quarter of fiscal year 1966 (affected by the 1965 amendment changing the definition of disability), the third quarter of fiscal year 1968 (affected by the 1967 amendment liberalizing eligibility requirements), and the third quarter of fiscal year 1974 (filing of SSI disability claims apparently are stimulating simultaneous filing of DIB claims).

Disability Insurance Application Rates and Unemployment Rates—Calendar Year 1967-73



	1967	1968	1969	1970	1971	1972	1973
Percent of Applications1/ to Number of Insured Workers	1.02%	1.26%	1.03%	1.20%	1.24%	1.24%	1.37%
Annual Average Percent of Insured Population Unemployed	2.5	2.2	2.1	3.4	4.1	3.5	2.7
Average Annual Percent2/ of All Civilian Workers Unemployed	3.8	3.6	3.5	4.9	5.9	5.6	4.9

1/ Applications received in Social Security District Office for Disability Program

2/ All civilian workers 16 years or older employed or looking for work

F. CONTINUING DISABILITY EVALUATION

Staff question: ***Please describe in more detail the system of examining continuing disability. What administrative entity has responsibility for initiating the process? Compare social security with SSI in this regard.***

Why have the statistics on continuing disability remained so static although the rolls have grown appreciably?

1. *The Continuing Disability Process and Organizational Responsibility*

Introduction

Under the provisions of the Social Security Act, we have the responsibility not only for payment of benefits to those who meet the statutory requirements for entitlement under the disability provisions, but also at the appropriate time for removing people from the benefit rolls when they are no longer disabled.

How continuing disability issues arise

Continuing disability questions arise in a number of ways.

Voluntary reports.—Beneficiaries are informed of their responsibility to report events which might have some bearing on their case. This is explained to them orally during the application interview and is repeated in the form of written instructions which are mailed with award notifications. This same process is repeated where a continuing disability investigation is undertaken and it is determined that disability continues. The usual method of reporting is a post card which the beneficiary completes showing improvement, return to work, work stoppage, change of address, or change of payee.

Reported earnings.—The Administration maintains a control on the earnings account of each individual for whom disability has been established. When appreciable wages or self-employment or agricultural earnings are reported for such an individual, they are examined with the claims file and, if it appears that an issue of continuance exists, an investigation is begun. Upon folder examination, we are able to screen out a sizable number of these notices. For example, we may find that the question raised by the particular notice has been previously considered and a decision made that the disability status would not be affected. If the question raised by the notice cannot be resolved by examination of the claims folder, it is necessary to obtain additional information from the beneficiary.

Medical reexamination diaries.—Future reexamination dates are established where the possibility exists that the individual will recover from his disabling condition. When the diary date is reached, the individual's continued entitlement is investigated by the State agencies.

Continuing disability investigations.—Investigations involving medical issues are conducted by the State agencies. The State agency usually undertakes direct development with the beneficiary in arriving at a sound determination as to whether the individual's disability continues or is no longer of such severity as to prevent him from engaging in substantial gainful activity. The SA decision is sent to BDI for review and notification to the individual of the outcome of the investigation.

Investigations involving work issues are initiated by BDI, by means of a questionnaire mailed to the beneficiary after he has completed his trial work period.[6] Where the information provided by the beneficiary is sufficient for a decision, the determination is prepared by BDI. Complex cases are sent to the district offices for personal contact with the beneficiary. Upon completion of the necessary development, determinations as to continuance or cessation are prepared by the district offices.

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[6] Disabled beneficiaries are permitted a trial work period of 9 months during which they can test their ability to resume substantial work. So long as a person continues to be disabled his work will not be evaluated until he has had a chance to perform services in at least 9 different months (these months need not be consecutive). If a beneficiary ceases to be disabled, i.e., he recovers medically from his condition, he may, of course, not receive a full 9 month trial work period; benefits in such a case will be terminated on the basis of recovery without regard to work activity. All beneficiaries, however, receive payments for the month disability ends and the following 2 months. This is true whether the cessation is based on recovery or a demonstrated ability to work.

Due process requirements.—In recent years the courts have given careful consideration to the policies and procedures for stopping or reducing benefits to assure that they provide administrative "due process." In the landmark case of *Goldberg* v. *Kelly*, involving payments under the Aid to Families with Dependent Children Program in New York, the Supreme Court ruled that before a recipient's payments may be stopped, he has a right to receive a notice detailing the reasons why his benefits are going to be stopped, an opportunity to confront any adverse witnesses and to present his own arguments and evidence orally.

In providing disabled beneficiaries with due process, every effort is made to assure that they are given the opportunity to understand the decision-making process, to react to it whenever there is a material conflict in the evidence or there is reason to believe that a beneficiary is unaware that the determination will be an adverse one, and to receive a response to his reaction. The key elements in this procedure consists of (1) notifying the beneficiary in advance of any proposed action to stop his disability benefits, (2) telling him the reasons for the proposed adverse action and (3) giving him an opportunity to submit rebuttal evidence before the adverse action is taken. These elements are not necessary when the proposed action to stop disability is initiated solely because of a report by the beneficiary himself (or his payee) and it is clear that he knew the effect of such report when he made it.

Currently there continues to be considerable interest by the courts in the question of whether existing procedures are adequate in satisfying due process or whether all beneficiaries should be provided with the opportunity to an oral hearing prior to the termination of disability benefits.

An opportunity for such an oral hearing is provided for title XVI recipient and for individuals receiving both title XVI and title II benefits.

2. *A Comparison of the Title II and Title XVI Continuing Disability Process*

Title XVI practically duplicates the title II continuing disability process. The primary differences are as follows:

(a) The mail questionnaire is not used for title XVI cases. Development is made directly with recipient by the DO.

(b) SGA determinations are prepared only in the district office, not in BDI.

(c) An individual's earnings during his title XVI Trial Work Period will be considered in determining his income and this will determine whether, under the income and resources requirement, benefits are payable during the Trial Work Period are not affected by the amount of the earnings.

(d) When an adverse determination is involved, before benefits may be stopped, the title XVI recipient is entitled to an oral hearing to satisfy due process requirements; the title II beneficiary is offered the opportunity of submitting rebuttal evidence in writing.

3. *Status on Continuing Disability*

The second part of the questions asks why the statistics on CD have remained so static although the benefit rolls have grown appreciably. BDI, too, has been interested in this phenomonon, and efforts are being made to find out why this is so with a view to taking any action which is appropriate.

Our inquiries, thus far, have identified a couple of things which might be noted. One is that there has been a declining mortality rate among disabled worker beneficiaries at least through 1971. Further, changes in the law since 1965 appear to have brought more beneficiaries onto the rolls with better survival expectations. Also, as shown by the data sent to you earlier, the number of terminations due to the attainment of age 65 have increased slower than the increase in the number of disabled workers in benefit status, at least through 1972. Overall, because the number of terminations due to recovery from disability traditionally accounts for a relatively small proportion of total disability terminations, the leveling out of such terminations has limited impact on the rate of total termination of disability benefits.

We are undertaking further analysis to determine more definitely what has caused the statistics on CD to remain static in the face of increasing beneficiaries going onto the rolls.

4. Continuing Disability Determinations, 1973

The table below shows for calendar year 1973 (1) why continuing disability investigations (CDI's) were triggered, (2) the number and percentage of cases investigated by reason, and (3) the number and percentage of cases ceased and continued by reason for the CDI.

The events and circumstances which result in the initiation of a CDI under Title II will also warrant a CDI under Title XVI except that if reported earnings from work activity are such that the individual is no longer eligible for supplemental security income payments because of excessive income or resources a CDI is unnecessary.

TABLE 88.—*Continuing disability determinations, calendar year 1973*

Why investigation was made	All cases [1]	Percent of total	Cessations	Percent of total	Continuances	Percent of total
Total	160, 627	100. 0	37, 926	100. 0	122, 701	100. 0
Medical re-exam diary	65, 143	40. 7	11, 949	31. 6	53, 194	43. 3
Trial work diary matured	9, 172	5. 7	7, 300	19. 2	1, 872	1. 5
Earnings posted—medical re-exam set	1, 043	. 6	399	1. 1	644	. 5
Earnings posted—medical re-exam not set	26, 346	16. 4	4, 062	10. 7	22, 284	18. 2
Voluntary report of return to work—medical recovery expected	7, 690	4. 8	4, 512	11. 9	3, 178	2. 6
Voluntary report of return to work—medical recovery not expected	20, 561	2. 8	4, 856	12. 8	15, 705	12. 8
Voluntary report of improvement or hospital discharge	4, 869	3. 0	551	1. 5	4, 318	3. 5
Voluntary report of work stoppage	7, 243	4. 5	56	. 1	7, 187	5. 9
Request for reconsideration, reopening, or higher appeal	5, 367	3. 3	3, 380	8. 9	1, 987	1. 6
Individual made his own payee, and other reason	10, 873	6. 8	624	1. 6	10, 249	8. 4
Rehabilitation notice	2, 320	1. 4	237	. 6	2, 083	1. 7

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[1] Cessations and continuances.

G. TRUST FUND OPERATIONS

TABLE 89.—*Operations of the disability insurance trust fund, calendar years 1957–77*

[In millions]

Calendar year	Transactions during period										
	Income				Disbursements						
	Total	Contributions, less refunds	Reimbursements from general fund of Treasury for cost of noncontributory credits for military service	Interest on investments	Total	Benefit payments	Payments for vocational rehabilitation services	Administrative expenses	Transfers to railroad retirement account	Net increase in fund	Fund at end of period
1957	$709	$702	---	$7	$59	$57	---	$3	---	$649	$649
1958	991	966	---	25	261	249	---	12	---	729	1, 379
1959	931	891	---	40	485	457	---	50	−$22	447	1, 825
1960	1, 063	1, 010	---	53	600	568	---	36	−5	464	2, 289
1961	1, 104	1, 038	---	66	956	887	---	64	5	148	2, 437
1962	1, 114	1, 046	---	68	1, 183	1, 105	---	66	11	−69	2, 368
1963	1, 165	1, 099	---	66	1, 297	1, 210	---	68	20	−133	2, 235
1964	1, 218	1, 154	---	64	1, 407	1, 309	---	79	19	−188	2, 047
1965	1, 247	1, 188	---	59	1, 687	1, 573	---	90	24	−440	1, 606

1966	2, 079	2, 006	$16	58	1, 947	1, 781	$3	137	25	133	1, 739
1967	2, 379	2, 286	16	78	2, 089	1, 939	11	109	31	290	2, 029
1968	3, 454	3, 316	32	106	2, 458	2, 294	16	127	20	996	3, 025
1969	3, 792	3, 559	16	177	2, 716	2, 542	15	178	21	1, 075	4, 100
1970	4, 774	4, 481	16	277	3, 259	3, 067	18	164	10	1, 514	5, 614
1971	5, 031	4, 620	50	361	4, 000	3, 758	24	205	13	1, 031	6, 645
1972	5, 572	5, 107	51	414	4, 759	4, 473	29	233	24	813	7, 457
1973	6,443	5,932	52	458	5,973	5,718	46	190	20	470	7,927
Estimated future experience (from 1973 Trustees Report):											
1974	7, 119	6, 605	52	462	6, 686	6, 295	68	280	43	433	8, 181
1975	7, 756	7, 198	66	482	7, 594	7, 089	80	293	42	242	8, 423
1976	8, 167	7, 603	84	480	7, 994	7, 562	86	305	40	173	8, 596
1977	8, 784	8, 228	87	459	8, 839	8, 383	95	318	43	−55	8, 541
Estimated future experience (from 1974 Trustees Report):											
Alternative I:											
1974 [1]	7,274	6,736	52	486	7,179	6,890	67	200	22	95	8,002
1975	8,205	7,648	66	491	8,265	7,922	83	240	20	—60	7,745
1976	9,032	8,470	89	473	9,249	8,883	99	253	14	−217	7,745
1977	9,883	9,345	95	443	10,292	9,896	113	269	14	−409	7,336
1978	11,012	10,487	101	424	11,288	10,864	127	281	16	−276	7,060
Alternative II:											
1974 [1]	7,281	6,742	52	487	7,179	6,890	67	200	22	102	8,029
1975	8,265	7,707	66	492	8,307	7,963	83	241	20	−42	7,987
1976	9,136	8,571	90	475	9,390	9,020	100	256	14	−254	7,733
1977	10,048	9,512	96	440	10,574	10,169	116	274	15	−526	7,207
1978	11,378	10,862	101	415	11,760	11,323	131	288	18	−382	6,825

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[1] Based on different assumption as to increases in Wage and Consumer Price Index which is outlined on p. 18 of the 1974 Trustees Report.

TABLE 90.—*Benefit payments under the old-age, survivors, and disability insurance program with respect to disabled beneficiaries, by trust fund, calendar years 1957–78*

[In millions]

Calendar year	Total [5]	Benefit payments [1] from—		
			Old-age and survivors insurance trust fund	
		Disability insurance trust fund [2]	Amount	As a percentage of total benefit payments with respect to disabled beneficiaries
Past experience:				
1957	$64	$57	$7	11. 1
1958	272	249	23	8. 5
1959	498	457	41	8. 2
1960	627	568	59	9. 4
1961	961	887	74	7. 7
1962	1, 194	1, 105	89	7. 4
1963	1, 311	1, 210	101	7. 7
1964	1, 422	1, 309	113	8. 0
1965	1, 707	1, 573	134	7. 9
1966	1, 932	1, 784	147	7. 6
1967	2, 113	1, 950	163	7. 7
1968	2, 523	2, 311	212	8. 4
1969	2, 806	2, 557	249	8. 9
1970	3, 386	3, 085	301	8. 9
1971	4, 146	3, 783	363	8. 8
1972	4 911	4, 502	409	8. 3
1973	6, 266	5, 764	502	8. 0
Estimated future experience: [3]				
1974	7, 532	6, 957	575	7. 6
1975	8, 649	8, 005	644	7. 4
1976	9, 687	8, 982	705	7. 3
1977	10, 778	10, 009	769	7. 1
1978	11, 819	10, 991	828	7. 0

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[1] Beginning in 1966, includes payments for vocational rehabilitation services.

[2] Benefit payments to disabled workers and their dependents.

[3] In interpreting the estimates, reference should be made to the accompanying text.

Source: Trustees Report, 1974, p. 33.

7. Standards and Rating of Disability

A. BASIS FOR ALLOWANCES—MEDICAL AND NONMEDICAL FACTORS

Staff question: ***At the time of the Harrison Committee, it was stated that 70 percent of claims were allowed on the basis of medical factors specifically listed: That 20 percent were allowed on the basis of an equivalent severity to listed factors; and 10 percent allowed with special weight given to non-medical factors. What are the relative roles of these factors in allowances today? Please give a narrative account of how these have changed, if they have, over the intervening years.***

At the time of the Harrison Subcommittee, the concepts of "meets the listings" and "equals the listings" did not really exist in the same formal sense as they do today. The concepts were used, but they were not formally developed nor as well-defined as they are now. Originally, an impairment could be said to "meet the listings" just by being mentioned in the listings; now, however, an impairment meets the listings only if the specific set of symptoms, signs and laboratory findings are the same as the set of symptoms, signs and laboratory findings specified in the listings. If an impairment does not meet the listings, the judgment as to whether an impairment equals the listings must now be made by a physician. It was not until the adoption of the more formal and structured sequential evaluation process by the Bureau of Disability Insurance (BDI) in the early 1960's that firm policy distinctions were made between the "meets" and "equals" concepts. The 1967 amendments led to further clarification and formalization of these concepts, which were then prescribed specifically in Social Security Regs. 404.1505 and 404.1506.

Early in the program, BDI's policies on how to apply vocational, educational, and age considerations to disability determinations existed as informal policy criteria. In 1961, policies on these non-medical subjects were clarified and formalized in Regs. 404.1502(b) and (c) so that they could be applied more uniformly in the making of disability determinations. The 1967 amendments led to further refinement by incorporating into the statute the "national economy test".

As the Listing of Impairments, the "meets" and "equals" concepts, and the non-medical policy considerations (vocational, educational, and age considerations) all underwent considerable change and development over the years, the gathering of data about them was necessarily affected. Because BDI's policies on these issues were originally not as clear and firm as they are now, there was not as much emphasis on labeling and coding disability determinations to show just how the above medical and non-medical factors applied in each case. As BDI's program and policies developed, the statistics and data-collection activities of the Bureau also became more sophisticated and refined. Thus, current data on these classifications are not fully comparable with the 1959 data.

Data currently available indicates that about 80% of allowances have been found by SA's to meet or equal the medical listings and the remainder allowed on the basis of vocational considerations. It should be noted, however, that the BDI Medical Consultant Staff has been working with a new approach to the rating of impairment severity in the review of a sample of State agency decisions. Our most recent experience with this review technique shows that the difference in judgment with respect to the adequacy of medical documentation between the State agency physicians and the BDI Medical Staff has not changed substantially over the past few years in allowed cases, but there is now closer agreement with respect to the adequacy of medical development in denied cases. However, the new technique shows greater differences of judgment in assessing the level of impairment severity. While the State agency physicians and BDI physicians do not differ greatly as to the percentage of allowed claims which "meet" the medical listings, there is a significant difference between the judgments with respect to the percentages of cases which "equal" the listings or which do not either "meet" or "equal" the listings.

We have not been able to develop specific adjudicative criteria for distinguishing levels of impairment severity below the level of "meets" the listings, and the assessment is therefore very largely a matter of the judgment of the physicians based upon the facts of each individual case. There is, therefore, a problem of determining conclusively the extent to which the assessments by the BDI physicians under the experimental review techniques are more valid than those made by the State agency physicians, although the BDI assessments do appear to be more repeatable.

We are continuing to study the new impairment severity rating technique to determine its applicability to the disability evaluation process, whether it is a technique which lends itself to use in the large, widely dispersed and decentralized State agency operation (as opposed to the small and tightly knit BDI Medical Staff), what the results of its utilization by State agencies would be, and whether those results would be compatable with the law and regulations. While we would hope to accomplish improvements in the application of the physician judgment and over time with this and other innovations in the disability evaluation process we believe progress will necessarily be evolutionary and over an extended time frame.

Differences in impairment severity characteristics of applicants over the years have not been analyzed fully enough to determine the extent to which they might contribute to differences in the basis for allowance.

B. MEDICAL CONSULTANT STAFF'S SYSTEM OF RATING DISABILITY

Staff question: ***Please furnish us a report of the Medical Consultant staff's system of rating disability determinations. Also provide us with the percent of population that falls within each category.***

The BDI medical consultant staff rating system and its reliability

A 5-point rating system and a scheme for combined ratings (when more than one type of impairment is established) has been used in the Sample Review Process since 1968. The rating system was designed to achieve the following objectives in order of importance: (1) To increase reliability of impairment severity assessment, (2) To provide a mechanism for distinguishing those applicants whose impairments are so minor that they do not interfere in any way with pursuit of substantial gainful activity (3) To provide a mechanism for distinguishing those applicants whose impairments are more than slight, but less than the level of severity implied in the listings.

The rating "5" is reserved for that degree of impairment defined by the regulatory medical evaluation criteria. The rating system provides a mechanism for ranking severity of impairment from none or slight (1 and 2) to that meeting or equalling the regulatory criteria (5). Intermediate ratings of 3 or 4 imply significant impairment which when associated with adverse vocational factors could result in a presumption of disability for any substantial gainful activity. The rating 5 distinguishes those applicants whose medical findings alone are sufficient to make a presumption that the applicant's allegation of inability to engage is reasonable. When an individual has distinct separate disorders or injuries each of which is rated by a separate specialist, the rating system has been constructed to provide for an overall final rating by combination of individual ratings made by separate medical specialists according to the attached scheme in Table II.

Since July 1, 1968, Medical Sample Review teams have completed ratings on impairments.

To test the reliability of the rating, we have used two physicians operating independently for the rating of each case. The reliability of the rating in terms of the results obtained on two independent ratings of each case is depicted in Table I.

The reliability of the rating system was tested in February and March 1969. The test was applied to 200 psychiatric cases, 235 medical cases, and 116 surgical cases. Within each specialty subgroup, each case was processed at least twice and the ratings for each pair of physicians have been analyzed for reliability. Physician assignment of cases was essentially random within the group of sample review physicians consisting of 19 internists, 2 neurologists (combined with the internists), 6 psychiatrists, and 6 surgeons. Group participation of these doctors was a function of availability, thus the results represent a cross section of reliability at that time. Each rater was unaware of the decision made by the State agency, as well as the rating made by the first physician rater. Cases in which either or both physicians requested additional documentation were deleted from reliability analysis. Two independent ratings were available on each of 551 fully documented cases.

Results

The basic data may be described as a bi-variate frequence distribution shown in Table 1. Ratings range from (1)—no impairment—to (5)—severe impairment meeting or equalling the regulatory medical criteria. As we expected, the two resulting distributions (marginal totals Table I) were similar since the raters were assigned to Set 1 or Set 2 at random. Set 1 had a mean of 3.40, Set 2 had a mean of 3.52. Standard deviation from the mean for Set 1 is 1.27; for Set 2, 1.22. The product moment correlation between the two sets of data was .8012, which may be interpreted as substantial agreement. Exact agreement, which may be indicated as the main diagonal from lower low left to upper right, was 60.3 percent. Agreement within one point between the two sets of ratings was found to be 512/551 or 92.7 percent. It is noted that relatively few of the cases were designated as having no impairment. The largest groups were designated as either a (3) or a (5). Considering ratings (2), (3), (4) and (5), rating (4) seems to be used less frequently than the others.

TABLE I: Two Independent Ratings on a Five-Point Severity Scale

		SET 1 - Ratings					
		1	2	3	4	5	
SET 2 - Ratings	5	0	2	6	30	142	180 (33%)
	4	0	1	34	21	15	71 (13%)
	3	9	42	114	4	10	179 (32%)
	2	20	45	30	3	1	99 (18%)
	1	10	5	7	0	0	22 (4%)
		39 (7%)	95 (17%)	191 (35%)	58 (11%)	168 (30%)	551

r = .8012 $S_{2,1}$ = .735

Set 1 mean = 3.4010

Standard dev.$_{(1)}$ = 1.2726

Set 2 mean = 3.5226

Standard dev.$_{(2)}$ = 1.2254

Exact agreement = 60.3%

Agreement within one point = 92.7%

TABLE II RATING COMBINATIONS

RATING WHEN 2 OR MORE SEPARATE DISORDERS ESTABLISHED

Ratings				FINAL RATING
5	-	-	=	5
4	4	4	=	5
4	4	3	=	5
4	4	-	=	5
4	3	3	=	5
4	3	-	=	4
4	-	-	=	4
3	3	3	=	4
3	3	-	=	4
3	-	-	=	3
3	2	2	=	3
3	2	-	=	3
3	-	-	=	3
2	2	2	=	2
2	2	1	=	2
2	1	1	=	2
1	1	1	=	1

C. The Nagi Study

COMPARISON OF STATE AGENCY ADJUDICATION OF WORK CAPACITY WITH THAT OF INDEPENDENT EVALUATION TEAMS—NAGI STUDY [1]

Some notice should be taken of the study of nearly 2,500 adjudicated cases in three separate State agencies—Louisiana, Minnesota, and Ohio, which were then reassessed by special clinical teams who categorized the cases by ability to work.[1] The overall results of the study are discussed rather extensively by Robert Dixon,[2] who believes that they show that the State agencies' adjudications, in contrast to those of the clinical teams, place heavy emphasis on physical limitations and underplay the psychological limitations. Dixon also notes:

> At the two extremes of fitness and unfitness there is a 26.9 percent and 27 percent discrepancy, respectively, between the clinical teams' determinations and SSA determinations. In the group treated by the clinical teams as more borderline ("fit for work under special conditions, including part-time") the allowance-denial rates are an even 50–50. Although these cases were a relatively small portion of the total Nagi sample, they could be expected to loom much larger in percent in the sample of total claims that ultimately reach hearing examiners (p. 72; this is derived from table 94).

What Dixon does not bring out is the State agency information in the study. Table 91, on its face, shows a great deal of consistency between the State agency adjudications and the clinical teams. Table 92 indicates, however, that this consistency is somewhat illusory. It shows that 16.9 percent (Louisiana), 20.4 percent (Minnesota), and 20.2 percent (Ohio) of those claimants who were allowed benefits were considered by the clinical teams as capable of working full- or part-time. On the other hand, of those denied benefits by the State agencies, 41.9 percent (Louisiana), 48.6 percent (Minnesota), and 49.8 percent (Ohio) were deemed by the clinical teams to be unable to work competitively. Overall, 19.3 percent of the State agencies' allowance and 47.9 percent of the denials differed from the determinations of the clinical teams.

Finally, case results were shown after the Central office review in Baltimore which indicated that changes in decisions "differed considerably" between State agencies, as well as the clinical teams. The Nagi report stated:

> The rates and directions of decision-reversal as a result of the final review differed considerably from one subsample to another. The lowest over-all rates of change occurred among Minnesota cases (3.2 percent), followed by those of Louisiana (4.2 percent), and Ohio (6.2 percent). Proportionately, there was greater change to allowance than to denial for cases from Louisiana and Minnesota. Ohio's cases exhibited a reverse pattern in which the percentage of change to denial was more than twice that in the other direction. The rate of change to denial among cases from Ohio was more than twice as high as the rate among cases from Louisiana and more than five times as high as that among cases from Minnesota. The frequencies involved in decision-change are too small for stable conclusions; however, the trends exhibited [in Table 93] as well as in earlier findings point out the need for further research in the characteristics of examiners and the organizational settings in which they operate, as sources of influence upon decisionmaking in disability determinations (pp. 88–89).

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[1] Saad Z. Nagi, "Disability and Rehabilitation, Legal, Clinical, and Self-Concepts and Measurement," Ohio State University Press, 1969. Although published in 1969 the actual study was undertaken in the period 1962–63 and financed by HEW.

[2] "Social Security and Mass Justice," pp. 65–73.

TABLE 91.—*Final determinations of disability and clinical evaluations for the 3 subsamples*

Subsamples	Number of cases	Final determinations (percent)		Clinical evaluations (percent)	
		Allowance	Denial	Unfit for competitive work	Fit for full- or part-time work
Louisiana	612	72.7	27.3	71.9	28.1
Minnesota	1,053	57.8	42.2	66.6	33.4
Ohio	789	57.8	42.2	67.2	32.8
Total	2,454	61.5	38.5	68.1	31.9

Source: Nagi, p. 95.

TABLE 92.—*Final determinations of disability and dichotomous clinical evaluations of applicants' work capacities for the subsamples*

Clinical evaluations of work capacities	Final determinations					
	Allowance		Denial		Total	
	Number	Percent	Number	Percent	Number	Percent
Louisiana:						
Can work full- or part time	75 (16.9)	43.6	97 (58.1)	56.4	172 (28.1)	100
Cannot work competitively	370 (83.1)	84.1	70 (41.9)	15.9	440 (71.9)	100
Total	445 (100.0)	72.7	167 (100.0)	27.3	612 (100.0)	100
Minnesota:						
Can work full or part time	124 (20.4)	35.2	228 (51.4)	64.8	352 (33.4)	100
Cannot work competitively	485 (79.6)	69.2	216 (48.6)	30.8	701 (66.6)	100
Total	609 (100.0)	57.8	444 (100.0)	42.2	1,053 (100.0)	100
Ohio:						
Can work full or part time	92 (20.2)	35.5	167 (50.2)	64.5	259 (32.8)	100
Cannot work competitively	364 (79.8)	68.7	166 (49.8)	31.3	530 (67.2)	100
Total	456 (100.0)	57.8	333 (100.0)	42.2	789 (100.0)	100
Total sample:						
Can work full or part time	291 (19.3)	37.2	492 (52.1)	62.8	783 (31.9)	100
Cannot work competitively	1,219 (80.7)	73.0	452 (47.9)	27.0	1,671 (68.1)	100
Total	1,510 (100.0)	61.5	944 (100.0)	38.5	2,454 (100.0)	100

Source: Nagi, p. 96.

TABLE 93.—*Decision changes in final determinations for the three subsamples*

Redeterminations	Final determinations					
	Allowance		Denial		Total	
	Number	Percent	Number	Percent	Number	Percent
Louisiana:						
Allowance	403	96. 9	13	3. 2	416	100. 1
Denial	11	7. 2	142	92. 8	153	100. 0
Total	414	72. 8	155	27. 2	569	100. 0
Minnesota:						
Allowance	548	98. 4	9	1. 6	557	100. 0
Denial	22	5. 2	402	94. 8	424	100. 0
Total	570	58. 1	411	41. 9	981	100. 0
Ohio:						
Allowance	427	91. 8	38	8. 2	465	100. 0
Denial	9	3. 1	281	96. 9	290	100. 0
Total	436	57. 7	319	42. 3	755	100. 0
Total sample:						
Allowance	1, 378	95. 8	60	4. 2	1, 438	100. 0
Denial	42	4. 8	825	95. 2	867	100. 0
Total	1, 420	61. 6	885	38. 4	2, 305	100. 0

Source: Nagi, p. 88.

TABLE 94.—*Final determinations of disability and the clinical teams' evaluations of work capacity of applicants*

Work capacity	Final determinations					
	Allowance		Denial		Total	
	Number	Percent	Number	Percent	Number	Percent
Fit for work under normal conditions			9	100. 0	9	100
Fit for specific jobs including former job, under normal conditions	23	13. 9	142	86. 1	165	100
Fit for specific jobs excluding former job, under normal conditions	94	36. 0	167	64. 0	261	100
Fit for work under special conditions	92	50. 5	90	49. 5	182	100
Can work part time under normal conditions	82	49. 4	85	50. 6	166	100
Can work under sheltered conditions	134	60. 6	87	39. 4	221	100
Can work at home only	66	69. 5	29	30. 5	95	100
Not fit for work	1, 019	75. 2	336	24. 8	1, 365	100
Total	1, 510	61. 5	944	38. 5	2, 454	100

Source: Nagi, p. 94.

Staff question: *Was there any follow-up by SSA to the 1970 Saad Z. Nagi publication titled, "Disability and Rehabilitation—Legal, Clinical, and Self-Concepts and Measurement"? If so, what did the follow-up consist of?*

One of the observations of the study related to the lack of guides for the assessment of rehabilitation potential. While such assessment is the primary responsibility of the agency for vocational rehabilitation, the indiscriminate rehabilitation referral of applicants for disability insurance benefits had long been observed as a wasteful process. In the past considerable reliance was placed on the training and experience of the disability adjudicator, many of whom had come from the rehabilitation discipline. In conjunction with the availability of trust funds monies for the rehabilitation, and consistent with observations made in the subject study, screening criteria have been developed by SSA in conjunction with SRS (RSA). These criteria are made available for State agencies to employ with appropriate modifications consistent with State and local circumstances. It is believed that these efforts have been partially responsible for the increased, orderly referral of claimants for rehabilitation and in the successful completion of rehabilitation programs by increasing numbers of referred disability insurance beneficiaries.

The subject publication was based on a research project sponsored by the Social and Rehabilitation Services Administration with the cooperation of the Bureau of Disability Insurance. It was designed to examine the concepts of disability and rehabilitation potential and, more specificially, to assess the methods of evaluating the applicants for disability insurance rehabilitation. Followup by SSA included: (1) clarification of regulations and medical guides for the assessment of psychiatric impairments, (2) increased utilization of medical evidence from applicants' treatment sources, (3) further clarification of criteria for adjudicating claims based on combined medical and vocational evidence, and (4) development of screening guides for referral for rehabilitation services.

(1) Some of the study observations resulted from comparing determinations made within the existing program structure with the determinations of capacity or incapacity made by the study team independent of the program criteria. This comparison suggested that psychological impairments were being overlooked as the basis for the disability determinations. The study showed a greater consistency of disability determinations with the severity of physical notations but a negative association with limitations of a pyschological nature. It was suggested that the most powerful explanation of the incongruencies resided in differences in conceptions of, and the weight given to, different types of limitations.

These observations were not inconsistent with case experience. When, subsequent to this study, the medical criteria were first published in the regulations, negative criteria relating to certain psychological impairments were removed. In addition, the criteria for the evaluation of psychiatric impairments were revised. Dependence upon psychiatric impairments were revised. Dependence upon psychiatric diagnosis was removed and, consistent with the study results, the assessment of functional restrictions manifested by these psychiatric impairments was stressed. These criteria now direct the adjudicator to assess restrictions in daily activities, construction of interests, and ability to relate to other people—factors which the study observed were seemingly not given appropriate consideration.

(2) A major element in the study was the comprehensive medical assessment given each of the subjects. While the benefits of such a comprehensive assessment were realized in added information concerning the nature, severity, and onset of impairments (including some not alleged by the claimant), the impracticality of routinely conducting such comprehensive examinations was observed. However, a followup by SSA in the form of an attending physician recontact survey clearly demonstrated that attending physicians had, on the whole, considerably more pertinent information concerning the nature, severity, and onset on the claimant's impairment than was initially provided; sometimes such information was more pertinent and more valuable for adjudication than that obtained in the comprehensive examinations.

D. Regulations Concerning Disability Evaluation [3]

RIGHTS AND BENEFITS BASED ON DISABILITY

404.1501 Disability defined

(a) *For Disability Benefits.*—(1) *Benefits for Months After August 1965.*—Disability means:

(i) For purposes of determining entitlement to disability insurance benefits under section 223 of the Act, or to child's insurance benefits (based on the child's disability) under section 202(d) of the Act, for months after August 1965, inability to engage in any substantial gainful activity by reason of any medical determinable physical or mental impairment or impairments which can be expected to result in death or which have lasted or can be expected to last for a continuous period of not less than 12 months;

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[3] Code of Federal Regulations, title 20, pt. 404, subpart P.

(ii) For purposes of determining entitlement to disability insurance benefits in a case of an individual who has attained the age of 55 and is blind (as defined in paragraph (*b*)(1)(ii)(A) of this section for benefits for months before February 1968 or for months after January 1968 based on applications filed before January 3, 1968, and in paragraph (*b*)(1)(ii)(B) of this section for benefits for months after January 1968 based on applications filed after January 2, 1968), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(iii) For purposes of determining entitlement to widow's or widower's insurance benefits (based on the widow's or widower's disability) under section 202 (e) or (f) of the Act, respectively, for months after January 1968, the existence of a medically determinable physical or mental impairment or impairments expected to result in death or which have lasted or can be expected to last for a continuous period of not less than 12 months and of a level of severity deemed (pursuant to § 404.1504) sufficient to preclude an individual from engaging in any gainful activity.

The meanings of "disability" described in this subparagraph (1) are applicable in the case of an application for (A) disability insurance benefits under section 223 of the Act of child's insurance benefits under section 202(d) of the Act filed after June 1965 (or before July 1965 if the individual did not die before July 1965, and notice of the Secretary's final decision on such application was not given before that month, or, if so given, a civil action was commenced to review such decision and the decision of the court thereon did not become final before July 1965); and (B) widow's insurance benefits under section 202(e) of the Act or widower's insurance benefits under section 202(f) of the Act, based on the disability of the widow or widower, filed in or after the month of January 1968.

(2) *Benefits for Months Before September 1965.*—For purposes of determining entitlement to disability insurance benefits or child's insurance benefits (based on the child's disability) for months before September 1965 (irrespective of date of application) "disability" means inability to engage in any substantial gainful activity because of any medically determinable physical or mental impairment which can be expected to continue for a long and indefinite period of time, or to result in death.

(b) *For Period of Disability.—(1) Application Filed or Final Decision Rendered After June 1965.*—For establishment of a period of disability where an application is filed after June 1965, "disability" means:

(i) Inability to engage in any substantial gainful activity because of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(ii) Blindness, without regard to ability to engage in any substantial gainful activity, hereinafter also referred to as "statutory blindness," which means (A) in the case of applications filed before January 3, 1968, central visual acuity of 5/200 or less in the better eye with the use of a correcting lens; an eye in which the visual field is reduced to 5° or less concentric contraction shall be considered as having a central visual acuity of 5/200 or less; and (B) in the case of applications filed after January 2, 1968, central visual acuity of 20/200 or less in the better eye with use of a correcting lens; an eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20° shall be considered as having a central visual acuity of 20/200 or less.

The meanings of "disability" described in this subparagraph (1) are also applicable to an application filed before July 1965 where the individual did not die before July 1965, and notice of the final decision of the Secretary on such application was not given to the individual before July 1965, or notice of the final decision of the Secretary was given, but a civil action was commenced to review such decision and the decision of the court thereon did not become final before July 1965.

(2) *Application Filed Before July 1965 and Final Disposition Before July 1965.*—For establishment of a period of disability where an application is filed before July 1965 and notice of the final decision of the Secretary was given before July 1965, or if a civil action to review such decision was commenced, the decision of the court thereon became final before July 1965; or if the individual died before July 1965, "disability" means:

(i) Inability to engage in any substantial gainful activity because of any medically determinable physical or mental impairment which can be expected to continue for a long and indefinite period of time or to result in death; or

(ii) Blindness, as defined in subparagraph (1)(ii)(A) of this paragraph.

(*c*) *Definition of Impairment.*—A physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. Statements of the applicant, including his own description of his impairment (symptoms) are, alone, insufficient to establish the presence of a physical or mental impairment. (Amended 8–20–68.)

404.1502 Evaluation of disability except for purposes of statutory blindness or widow's or widower's benefits

(*a*) Whether or not an impairment in a particular case involving disability insurance benefits under section 223 of the Act (except for purposes of statutory blindness) or child's insurance benefits based on disability under section 202(d) of the Act or a period of disability under section 216(i)(1)(A) of the Act constitutes a disability, as defined in § 404.1501, is determined from all the facts of that case. Primary consideration is given to the severity of the individual's impairment. Consideration is also given to such other factors as the individual's age, education, and work experience. Medical considerations alone can justify a finding that the individual is not under a disability where the only impairment is a slight neurosis, slight impairment of sight or hearing, or other slight abnormality or a combination of slight abnormalities. On the other hand, medical considerations alone (including the physiological and psychological manifestations of aging) can, except where other evidence rebuts a finding of "disability," e.g., the individual is actually engaging in substantial gainful activity, justify a finding that the individual is under a disability where his impairment is one that meets the duration requirement in § 404.1501, and is listed in the appendix to this subpart or the Secretary determines his impairment (or combined impairments) to be medically the equivalent of a listed impairment (*see* §404.1505).

(*b*) Conditions which constitute neither a listed impairment nor the medical equivalent thereof likewise may be found disabling if they do, in fact, prevent the individual from engaging in any substantial gainful activity. Such an individual, however, shall be determined to be under a disability only if his physical or mental impairment or impairments are the primary reason for his inability to engage in substantial gainful activity. In any such case it must be established that his physical or mental impairment or impairments are of such severity, i.e., result in such lack of ability to perform significant functions as moving about, handling objects, hearing, speaking, reasoning, and understanding, that he is not only unable to do his previous work or work commensurate with his previous work in amount of earnings and utilization of capacities but cannot, considering his age, education, and work experience, engage in in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For the purposes of the preceding sentence, work "exists in the national economy" with respect to any individual, when such work exists in significant numbers either in the region where such individual lives or in several regions of the country. Thus, isolated jobs of a type that exist only in very limited number or in relatively few geographic locations shall not be considered to be "work which exists in the national economy" for purposes of determining whether an individual is under a disability; an individual is not denied benefits on the basis of the existence of such jobs. Accordingly, where an individual remains unemployed for a reason or reasons not due to his physical or mental impairment but because he is unsuccessful in obtaining work he could do; or because work he could do does not exist in his local area; or because of the hiring practices of employers, technological changes in the industry in which he has worked, or cyclical economic conditions; or because there are no job openings for him or he would not actually be hired to do work he could otherwise perform, the individual may not be considered under a disability as defined in § 404.1501.

(*c*) Where an individual with a marginal education and long work experience (e.g., 35 to 40 years or more) limited to the performance of arduous unskilled physical labor is not working and is no longer able to perform such labor because of a significant impairment or impairments and, considering his age, education, and vocational background is unable to engage in lighter work, such individual may be found to be under a disability. On the other hand, a different conclusion may be reached where it is found that such individual is working or has worked despite his impairment or impairments (except where such work is sporadic or is medically contraindicated) depending upon all the facts in the case. In addition, an individual who was doing heavy physical work at the time he suffered such impairment might not be considered unable to engage in any substantial gainful activity if the evidence shows that he has the training or past work experience which qualifies him for substantial gainful work in another occupation consistent with his impairment, either on a full-time or a reasonably regular part-time basis.

EXAMPLE: B, a 60-year old miner, with a fourth grade education, after a life-long history of arduous physical labor alleged that he was under a disability because of arthritis of the spine, hips, and knees and other impairments. Medical evidence shows a combination of impairments and establishes that these impairments prevent B from performing his usual work or any other type of arduous physical labor. His vocational background does not disclose either through performance or by similarly persuasive evidence that he has skills or capabilities needed to do lighter work which would be readily transferable to another work environment. Under these circumstances, B may be found to be under a disability.

(*d*) When used in this section for evaluating "disability," the term "age" refers to chronological age and the extent to which it affects the individual's capacity to engage in work in competition with others. An individual unemployed primarily because of age, however, shall not be deemed unable to engage in substantial gainful activity by reason of a medical impairment.

(*e*) When used in this section for evaluating "disability," the term "education" is used in the following sense: Education and training are factors in determining the employment capacity of an individual. Lack of formal schooling, however, is not necessarily proof that the individual is an uneducated person. The kinds of responsibilities he carried when working may indicate ability to do more than unskilled work, even though his formal education has been limited. (Paragraphs (*a*), (*f*), and (*g*) amended and paragraph (Section amended 8–20–68.)

404.1503 Evaluation of disability—individual has attained age 55 and is statutorily blind

An individual who has attained age 55 and is statutorily blind (*see* §404.1501(*b*)(1)(ii)) may establish entitlement to disability insurance benefits, under the provisions described in §404.1501(*a*)(1)(ii) even though he is working or has worked in substantial gainful activity (*see* §404.1534) since attainment of age 55 or the onset of statutory blindness, which ever is later, if the skills or abilities be utilized in such work are not comparable to those of any gainful activity in which he previously engaged with some regularity and over a substantial period of time. However, no payment may be made to such an individual for any month in which he engaged in any substantial gainful activity even though noncomparable (*see* §404.1534). (Added 8–20–68).

404.1504 Evaluation of disability—widows and widowers

A widow or widower shall, for purposes of section 202 (e) or (f) of the Act, be determined to be under a disability only if, in the absence of evidence that he or she is engaged in substantial gainful activity—

(*a*) His or her impairment or impairments meet the duration requirement in §404.1501 and are listed in the appendix to this subpart; or

(*b*) His or her impairment or impairments are not listed in the appendix to this subpart, but singly or in combination meet the duration requirement in §404.1501 and are determined by the Secretary to be medically the equivalent of a listed impairment.

Such an individual shall not be found under a disability, however, where he or she is engaged in substantial gainful activity. (Added 8–20–68.)

404.1505 Determining medical equivalence

(*a*) An individual's impairment or impairments shall be determined to be medically the equivalent of an impairment listed in the appendix to this Subpart P, only if the medical findings with respect thereto are at least equivalent in severity and duration to the listed findings of the listed impairment.

(*b*) Any decision made under § 404.1502, § 404.1504, or §404.1539 as to whether an individual's impairment or impairments are medically the equivalent of an impairment listed in the appendix to this Subpart P, shall be based on medical evidence demonstrated by medically acceptable clinical and laboratory diagnostic techniques, including a medical judgment furnished by one or more physicians designated by the Secretary, relative to the question of medical equivalence. A "physician designated by the Secretary" shall include a physician in the employ of or engaged for this purpose by the Administration, the Railroad Retirement Board, or a State agency authorized to make determinations of disability. (Added 8–20–68.)

404.1506 Listing of impairments in appendix

(*a*) The Listing of Impairments describes, for each of the major body systems, impairments which—

(1) Are of a level of severity deemed sufficient to preclude an individual from engaging in any gainful activity; and

(2) Are expected to result in death or to last for a continuous period of not less than 12 months.

(*b*) Each section is preceded by a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some of which are identified as essential in establishing a diagnosis or in confirming the existence of an impairment for the purpose of this Listing, are also cited in the narrative introduction. Where the medical findings essential to support a diagnosis are not specified in the introduction or elsewhere in the Listing, the diagnosis must nonetheless be established on the basis of medically acceptable clinical and laboratory diagnostic techniques. For certain of the listed categories only a pathophysiologic diagnosis is required. Following the introduction in each section, the requisite level of severity of impairment is specified under "Category of Impairments" by one or more sets of medical findings. The medical findings consist of symptoms, signs and laboratory findings. For the purposes of this Subpart P, the following definitions apply:

(1) *Symptoms* are the claimant's own description of his physical or mental impairment.

(2) *Signs* are anatomical, physiological or psychological abnormalities which are demonstrable, apart from the claimant's symptoms, by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena, apart from the claimant's symptoms, indicating specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality.

(3) *Laboratory* findings are manifestations of anatomical, physiological, or psychological phenomena which are demonstrable by the use of medically acceptable laboratory diagnostic techniques which extend or replace the perceptiveness of the senses, including chemical tests, electrophysiologic or roentgenologic studies and pyschological tests.

(c) An impairment shall not be considered to be one listed in the appendix to this Subpart P solely because it has the name of a listed impairment. To be considered a listed impairment, it must also have such attendant findings as are recited in the Listing for the impairment. (Added 8-20-68).

APPENDIX LISTING OF IMPAIRMENTS[1]

Listing of impairments

	Section
Musculoskeletal System	1. 00
Special Sense Organs	2. 00
Respiratory System	3. 00
Cardiovascular System	4. 00
Digestive System	5. 00
Genito-Urinary System	6. 00
Hemic and Lymphatic System	7. 00
Skin	8. 00
Endocrine System	9. 00
Multiple Body Systems	10. 00
Neurological	11. 00
Mental Disorders	12. 00
Neoplastic Diseases—Malignant	13. 00

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[1] Added Aug. 20, 1968.

1.00 *Musculoskeletal System*

A. Functional loss may be due to an anatomical loss or to a loss of use of a part due to deformity, adhesions, defective innervation, or other pathology. Pain may be an important factor in causing functional loss, but it must be associated with relevant abnormal findings. Evaluations of musculoskeletal impairments should be supported where applicable by detailed descriptions of ranges of motion, status of the musculature and any sensory, reflex or circulatory deficits and pertinent X-ray findings.

B. Major joints as used herein refer to hip, knee, ankle, shoulder, elbow or wrist and hand. (Wrist and hand considered together as one major joint.)

C. The measurements of restricted motion and ankylosis are based on the technic of measurements described in "Guides to the Evaluation of Permanent Impairment Extremities and Back" by the Committee on Rating of Mental and Physical Impairment, Special Edition, JAMA, February 15, 1958.

1.01 *Category of Impairments, Musculoskeletal*

1.02 Rheumatoid Arthritis.—With:

A. History of joint pain and swelling in two or more major joints and morning stiffness persistent on activity; and

B. Signs of joint enlargement, or effusion, and motion limitation with periarticular muscle wasting in two or more major joints; and

C. X-ray evidence of abnormality of a major joint (i.e., osteoporosis or decalcification or narrowing of joint space) and one of the following:

1. Anatomical deformity in one or more joint, such as joint subluxation, contracture, bony or fibrous ankylosis, joint instability, ulnar deviation, or hyperextension, with resultant limitation of motion; or
2. Positive serologic test for rheumatoid factor; or
3. Elevated sedimentation rate (Wintrobe) greater than 20 mm. per hour in females or 10 mm. per hour in males; or
4. Positive C-reactive protein; or
5. Polymorphonuclear leukocytosis in synovial fluid aspirate; or
6. Characteristic histologic changes in biopsy of synovial membranes or subcutaneous nodule.

1.03 Neurogenic Arthropathy (e.g., Charcot) Affecting at Least One Major Weight-Bearing Joint or One Major Joint in Each of the Upper Extremities.—With:

A. Instability or subluxation; and

B. Associated loss of sensory modalities in appropriate distribution.

1.04 Hypertrophic (Osteo or Dengenerative), Gouty, Infectious or Traumatic Arthritis.—With:

A. History of pain and stiffness in the involved joints; and

B. X-ray evidence of joint space narrowing with osteophytosis (exostosis) or bony destruction with erosions and cysts, or subluxation, or ankylosis of involved joints and one of the following:

1. Abduction of both arms at shoulders restricted to less than 90 degrees; or
2. Ankylosis (fibrous or bony consolidation or fixation) of hip at less than 20 degrees or more than 30 degrees of flexion, measured from neutral position; or
3. Ankylosis or fixation of knee at more than 10 degrees from neutral position; or
4. Limitation of flexion of both hips to 50 degrees or less from neutral position (including ankylosis of both hips at any angle); or
5. Limitation of flexion of both knees to 30 degrees or less from the neutral position (including ankylosis of both knees at any angle); or
6. Combined involvement of single hip and knee in contralateral extremity, with impairment in each as in 4 or 5 above; or
7. Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint (hip, knee, ankle, or tarsal region) and return to full weight-bearing status did not occur, or is not expected to occur within 12 months of onset of disability; or
8. X-ray evidence of lumbar spine abnormalities as in B above with motion of dorsolumbar spine limited to 5 degrees or less from neutral position and impairment of single hip or knee as in 4 or 5 above.

1.05 Disorders of Spine.—With:

A. Fracture of vertebra, residuals of. With cord involvement with appropriate sensory and motor loss; or

B. Generalized osteoporosis with pain, limitation of back motion, paravertebral muscle spasm, and compression fracture of a vertebra; or

C. Ankylosis or fixation of cervical or dorsolumbar spine at 30 degrees or more of flexion measured from the neutral position and one of the following:

1. Calcification of the anterior and lateral ligaments as shown by X-ray; or
2. Bilateral ankylosis of sacroiliac joints and abnormal apophyseal articulations as shown by X-ray.

1.06 Tuberculosis of the Spine or Any Major Joint.—Active.

1.07 Nerve Root Compression Syndrome (Due to Any Cause).—With:

A. Pain and motion limitation in back or neck; and

B. Cervical or lumbar nerve root compression as evidenced by appropriate radicular distribution of sensory, motor, and reflex abnormalities.

1.08 Osteomyelitis (Demonstrated by X-Ray).—A. Pelvis, vertebra, femur, tibia or a major joint of an upper or lower extremity, with persistent activity or occurrence of at least 2 episodes in the 6 months since onset of disability manifested by local or systematic signs or laboratory findings (e.g., heat, redness, swelling, drainage, leucocytosis, or increased sedimentation rate); or

B. With multiple localizations and systemic manifestations such as anemia (hematocrit of 30 percent or less) or amyloid changes.

1.09 Amputation of; or Anatomical Deformity of (i.e., Loss of Major Function Due to Degenerative Changes Associated With Vascular or Neurological Deficits, Traumatic Loss of Muscle Mass or Tendons and X-Ray Evidence of Bony or Fibrous Ankylosis at an Unfavorable Angle, Joint Subluxation or Instability).—A. Both hands; or

B. Both feet; or

C. One hand and one foot.

1.10 Amputation of Lower Extremity (at or above the Tarsal Region).—A. Hemipelvectomy or hip disarticulation; or

B. Evaluate an amputation associated with peripheral vascular disease or diabetes mellitus under the criteria in § 4.13 or § 9.08; or

C. Inability to use prosthesis effectively, without other assistive devices, due to:

1. Vascular disease; or
2. Neurological complications (e.g., loss of position sense); or
3. Stump complications persisting, or expected to persist, for at least 12 months from onset of disability; or
4. Disorder of contralateral lower extremity causing mobility restriction.

1.11 Fracture of Femur, Tibia, Tarsal Bone or Pelvis.—With solid union not evident on X-ray and return to full weight-bearing status did not occur, or is not expected to occur, within 12 months of onset.

1.12 Fractures and/or Soft Tissue Injuries of an Upper Extremity.—A. With non-union of a fracture of the shaft of the humerus, radius, or ulna under continuing surgical management directed toward restoration of functional use of the extremity and such function was not restored or expected to be restored withing 12 months after onset; or

B. Requiring a series of staged surgical procedures within 12 months after onset for salvage and/or restoration of major function of the extremity, and such major function was not restored or expected to be restored within 12 months after onset; or

C. After maximum benefit from surgical therapy has been achieved (i.e., there have been no significant changes in physical findings and/or X-ray findings for any 6-month period after the last definitive surgical procedure), the residual of fractures and/or soft tissue injuries of an upper extremity should be evaluated under the criteria in § 1.09 when associated with residual impairment of another extremity.

2.00 Special sense organs

A. *Causes of Disability.*—Disease or injury of the special sense organs may produce disability by reduction of the ability to see or hear. Loss of central vision results in inability to distinguish detail and prevents reading and fine work. Loss of peripheral vision restricts the ability of an individual to move about freely. Loss of hearing impairs ability to communicate with others by misinterpretation of ideas and orders and results in lack of awareness to danger. The extent of impairment of sight or hearing should be determined by visual or auditory testing.

B. *Central Visual Acuity.*—A loss of central visual acuity may be caused by impaired distant and/or near vision. However, for an individual to meet the level of severity described in §§2.02 and 2.04 only the remaining central visual acuity for distance of the better eye with best correction using the Snellen test chart may be used. Correction obtained by special visual aids (e.g., contact lenses) will be considered only if the individual has the ability to wear such aids.

C. *Field of Vision.*—Disability due to loss of peripheral vision may result if there is contraction of the visual fields. The contraction may be either symmetrical or irregular. For the phakic eye (the eye with a lens), the extent of the remaining visual field will be determined by usual perimetric methods, utilizing a 3 mm. white disc target at a distance of 330 mm. under illumination of not less than 7 foot-candles. For the aphakic eye (the eye without a lens), the visual field must be determined by utilizing a 6 mm. white disc at a distance of 330 mm. without corrective lenses.

Field measurements must be accompanied by notated field charts, a description of the type and size of the target and the test distance. If corrective lenses have been used, this fact must be stated.

D. *Muscle Function.*—Paralysis of the third cranial nerve producing ptosis, paralysis of accommodation, and dilation and immobility of the pupil may cause significant visual impairment. When all the muscles of the eye are paralyzed, including the iris and ciliary body (total ophthalmoplegia), the condition is disabling provided it is bi-lateral. A finding of disability based primarily on impaired muscle function must be supported by a report of an actual measurement of ocular motility.

E. *Visual Efficiency.*—Loss of visual efficiency may be caused by disease or injury resulting in a reduction of central visual acuity and/or visual field. The visual efficiency of one eye is the product of the percentage of central visual efficiency and the percentage of visual field efficiency. (See Tables No. 1 and 2, § 2.09.)

F. *Special Situations.*—Aphakia represents a visual handicap in addition to the loss of central visual acuity. The term monocular aphakia would apply to an individual who has had the lens removed from one eye, and who still retains the lens in his other eye or to an individual who has only one eye which is aphakic. The term binocular aphakia would apply to an individul who has had both lenses removed. In cases of binocular aphakia, the central visual efficiency of the better eye will be accepted as 75 percent of its value. In cases of monocular aphakia, where the better eye is aphakic, the central visual efficiency will be accepted as 50 percent of its value. (If an individual has binocular aphakia, and the central visual acuity in the poorer eye can be corrected only to 20/200, or less, the central visual efficiency of the better eye will be accepted as 50 percent of its value.)

Ocular symptoms of systemic disease may or may not produce a disabling visual impairment. These manifestations should be evaluated as part of the underlying disease entity by reference to the particular body system involved.

G. *Deafness.*—Deafness should be evaluated in terms of the person's ability to hear and distinguish speech. The degree of functional hearing loss is that loss of hearing and discrimination for speech which is not restorable by a hearing aid. Loss of hearing may be determined with an audiometer or by other appropriate auditory testing. Discrimination for speech may be determined with a speech audiometer or a hearing aid and the use of phonetically balanced word lists (e.g., the PB–50's prepared at Harvard University or the W–22 recordings developed by the Central Institute for the Deaf.) These special test lists consist of words selected so that the frequency of speech sounds in the group is the same as the frequency of the same sounds in an average vocabulary of conventional American English.

2.01 Category of impairments, special sense organs

2.02 Impairment of Central Visual Acuity.—Remaining vision in the better eye after best correction is 20/200 or less.

2.03 Contraction of Visual Fields.—A. To 10 degrees or less from the point of fixation; or

B. So the widest diameter subtends an angle no greater than 20 degrees; or

C. To 20 percent or less visual field efficiency.

2.04 Loss of Visual Efficiency.—Visual efficiency of better eye after best correction, 20 percent or less. (The percent of remaining visual efficiency = the product of the percent of remaining central visual efficiency and the percent of remaining visual field efficiency.)

2.05 Complete Homonymous Heminaopsia.—

2.06 Total Bilateral Ophthalmoplegia.—

2.07 Meniere's Syndrome.—Severe, with frequent and typical attacks, vertigo, deafness, and cerebellar gait.

2.08 Hearing Impairments (Not Correctible by a Hearing Aid).—Manifested by:

A. Absence of air and bone conduction in both ears (auditory perception of not more than one pure tone at high volume will be considered as absence of air and bone conduction); or

B. No more than 40 percent discrimination for speech (ability to hear and understand no more than 40 out of 100 words of special test lists of words using a speech audiometer or hearing aid).

2.09 Tables.—

Table No. 1—Percentage of Central Visual Efficiency Corresponding to Central Visual Acuity Notations for Distance in the Phakic and Aphakic Eye (Better Eye).

Snellen		Percent central visual efficiency		
English	Metric	Phakic [1]	Aphakic Monocular [2]	Aphakic Binocular [3]
20/16	6/5	100	50	75
20/20	6/6	100	50	75
20/25	6/7.5	95	47	71
20/32	6/10	90	45	67
20/40	6/12	85	42	64
20/50	6/15	75	37	56
20/64	6/20	65	32	49
20/80	6/24	60	30	45
20/100	6/30	50	25	37
20/125	6/38	40	20	30
20/160	6/48	30	----------------	22
20/200	6/60	20	----------------	----------------

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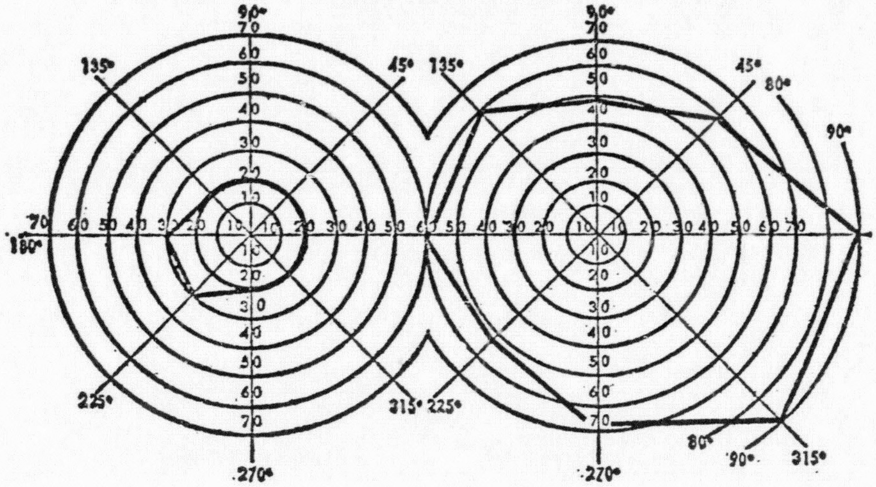
[1] Use: 1. A lens is present in both eyes. 2. A lens is present in the better eye and absent in the poorer eye. 3. A lens is present in 1 eye and the other eye is enucleated.

[2] Use: 1. A lens is absent in the better eye and present in the poorer eye. 2. The lenses are absent in both eyes; however, the central visual acuity in the poorer eye after best correction is 20/200 or less. 3. A lens is absent from 1 eye and the other eye is enucleated.

[3] Use: 1. The lenses are absent from both eyes and the central visual acuity in the poorer eye after best correction is greater than 20/200.

Table No. 2—Chart of Visual Field Showing Extent of Normal Field and Method of Computing % of Visual Field Efficiency



LEFT EYE (O.S.) RIGHT EYE (O.D.)

1. Diagram of right eye illustrates extent of normal visual field as tested on standard perimeter at 3/330 (3 mm. white disc at a distance of 330 mm.) under 7 foot-candles illumination. The sum of the eight principal meridians of this field total 500 degrees.

2. The percent of visual field efficiency is obtained by adding the number of degrees of the eight principal meridians of the contracted field and dividing by 500. Diagram of left eye illustrates visual field contracted to 30 degrees in the temporal and down and out meridians and to 20 degrees in the remaining six meridians. The percent of visual field efficiency of this field is: $6\times20+2\times30=180\div500=0.36$ or 36 percent remaining visual field efficiency, or 64 percent loss.

3.00 Respiratory system

A. Cause of disability: The disability produced by respiratory disease usually results from chronic recurrent infection, communicability or from pulmonary insufficiency or a combination of these factors.

B. Pulmonary tuberculosis is a communicable disease and disability is determined primarily on the basis of activity of the disease. Individuals with "inactive" or "quiescent" disease are not considered to be under a disability on the basis of tuberculosis, whereas individuals with "active" tuberculosis are considered to be under a disability.

Those individuals who meet the criteria described in § 3.08 for pulmonary tuberculosis will be found to have a disabling impairment which is expected to last for a period of at least 12 months. Proposed or accomplished surgery will not militate against such a finding. Impairment of pulmonary function due to extensive pulmonary tuberculosis should be evaluated under the appropriate listing.

Documentation.—The clinical activity of pulmonary tuberculosis (i.e., active, inactive, or quiescent) and the criteria which describe the extent of the pulmonary lesion on reontgenogram (i.e., minimal, moderate, or far advanced) are defined in the National Tuberculosis Association's publication, "Diagnostic Standards and Classification of Tuberculosis." Tuberculosis will be considered to be present only when when Mycobacterium tuberculosis has been demonstrated by a culture, or by guinea pig inoculation, of a specimen(s) from sputum, gastric aspirate, pleural fluid, or lung tissue. A "positive" culture is a culture in which colonies of M. tuberculosis are present. The date of a culture is the date of specimen collection. If the date of collection is unknown, it will be assumed that the specimen was collected 6 weeks prior to the date of the report of the culture. Where specimens have not been cultured or reported monthly, the intervening specimen(s) will be considered to have been negative, if a current specimen is negative. Suspected or questionable cavitary disease identified on the basis of a conventional PA 14 x 17 film will be considered to be noncavitary.

C. *Pathogenic Atypical Mycobacteria.*—Pulmonary infection caused by these organisms will be considered under the same criteria as for M. tuberculosis except that specimens obtained by gastric aspirations are not acceptable. The pathogenic atypical mycobacteria are contained in Runyon Groups I, III, and IV. The scotochromogens in Group II are not considered pathogens. A report of one to 10 colonies on culture will not be considered as a "positive" culture. The presence of sporadic positive cultures of atypical mycobacteria occurring after disease caused by M. tuberculosis has been established does not denote reactivation of pulmonary tuberculosis.

D. *When a respiratory impairment is episodic in nature,* as may occur in complications of bronchiectasis and mycotic infections of the lung, the frequency of severe episodes is the criterion for determining level of impairment.

E. *Cor Pulmonale.*—Chronic cor pulmonale as used in § 3.11 refers to a condition in which the right ventricle is enlarged as a consequence of a primary respiratory disease. Therefore, the clinical diagnosis of the respiratory disorder must be established by history, physical findings and chest X-ray. Right ventricular enlargement or outflow tract prominence may be difficult to detect on routine PA film, particularly in the presence of chronic obstructive airway disease. Consequently, lateral and oblique films or chest fluoroscopy should be obtained, unless cardiac enlargement is established by the PA film as per § 4.02.

F. *Documentation of Pulmonary Insufficiency.*—Spirometric studies for evaluation under Tables I, II, and IV must be expressed in liters or liters per minute. The reported maximum voluntary ventilation (MVV) or maximum breathing capacity (MBC) and one second forced expiratory volume (FEV_1) should represent the largest of at least three attempts. The MVV or the MBC reported should represent the observed value and should not be calculated from FEV_1. The appropriately labeled spirometric tracing, showing distance per second on the abscissa and the distance per liter on the ordinate, must be incorporated in the file. The paper speed to record the FEV_1 should be sufficiently fast for measurement of volume to the nearest 0.1 liter. The height of the individual must be recorded. Studies should not be performed during or soon after an acute respiratory illness. If wheezing is present on auscultation of the chest, studies must be performed following administration of nebulized broncho-dilator. A statement should be made as to the individual's ability to understand the directions, and cooperate in performing the test.

3.01 Category of impairments respiratory

3.02 Chronic Obstructive Airway Disease (Chronic Bronchitis, Chronic Asthmatic Bronchitis or Pulmonary Emphysema With or Without Abnormal X-Ray Findings):—With:

Spirometric evidence of airway obstruction demonstrated by MVV and FEV_1 both equal to, or less than, the values specified in Table I, corresponding to the applicant's height.

Table I

Height (inches)	MVV (MBC) equal to or less than, (L./Min.)	FEV_1 equal to or less than (L.)
57 or less	32	1. 0
58	33	1. 0
59	34	1. 0
60	35	1. 1
61	36	1. 1
62	37	1. 1
63	38	1. 1
64	39	1. 2
65	40	1. 2
66	41	1. 2
67	42	1. 3
68	43	1. 3
69	44	1. 3
70	45	1. 4
71	46	1. 4
72	47	1. 4
73 or more	48	1. 4

3.03 Bronchial Asthma, Allergic or Atopic (Not Due Primarily to Heart Disease or Bronchial Infection).—Evaluate under the criteria in § 3.02.

3.04 Diffuse Pulmonary Fibrosis (Sarcoidosis, Hamman-Rich Syndrome, Idiopathic Interstitial Fibrosis, and Similar Diffuse Fibroses Substantiated by Chest X-Ray or Tissue Diagnosis. This Category Does Not Include Cases of Bronchitis or Emphysema With Incidental Scarring or Scattered Parenchymal Fibrosis on X-Ray).—With:

A. Total vital capacity equal to, or less than, values specified in Table II below corresponding to the applicant's height.

Table II

Height (inches)	*V.C. equal to or less than (L.)*
57 or less	1.2
58	1.3
59	1.3
60	1.4
61	1.4
62	1.5
63	1.5
64	1.6
65	1.6
66	1.7
67	1.7
68	1.8
69	1.8
70	1.9
71	1.9
72	2.0
73 or more	2.0

or

B. Diffusing capacity of the lungs for carbon monoxide less than 6 ml./mm. Hg./min. (steady-state methods) or less than 9 ml./mm. Hg./min. (single-breath methods) or less than 30 percent of predicted normal. (All methods-actual values and predicted normal for the method used should be reported); or

C. Arterial oxygen saturation at rest and simultaneously determined arterial pCO_2 equal to, or less than, the values specified in Table III.

Table III

Arterial pCO_2 and	*Arterial O_2 saturation equal to or less than (percent)*
30 mm. Hg. or below	93
31 mm. Hg	93
32 mm. Hg	92
33 mm. Hg	92
34 mm. Hg	91
35 mm. Hg	91
36 mm. Hg	90
37 mm. Hg	89
38 mm. Hg	88
39 mm. Hg	88
40 mm. Hg. or above	87

3.05 Other Restrictive Ventilatory Disorders (e.g., Kyphoscoliosis, Thoracoplasty, Pulmonary Resection).—With:

Total vital capacity equal to, or less than, values specified in Table IV corresponding to the applicant's height.

Table IV

Height (inches)	*V.C. equal to or less than (L.)*
59 or less	1. 0
60	1. 1
61	1. 1
62	1. 1
63	1. 1
64	1. 2
65	1. 2
66	1. 2
67	1. 3
68	1. 3
69	1. 3
70 or more	1. 4

3.06 Pneumoconiosis Demonstrated by X-Ray Evidence.—With:

A. Nodular or focal fibrosis (non-conglomerative). Evaluate under the criteria for chronic obstructive airway disease in §3.02; or

B. Interstitial or disseminated fibrosis or conglomerative disease. Evaluate under the criteria for pulmonary fibrosis in §3.04; or

C. Where A and B are mixed or cannot be differentiated—evaluate under the criteria in §3.02 or §3.04.

3.07 Bronchiectasis (Demonstrated by Radio-Opaque Material).—With:

A. Episodes of acute bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) occurring at least once every 2 months; or

B. Impairment of pulmonary function due to extensive disease should be evaluated under the criteria for chronic obstructive airway disease in §3.02 or where extensive fibrosis is evident on chest film, under the criteria for pulmonary fibrosis in §3.04.

3.08 Pulmonary Tuberculosis (Caused by M. Tuberculosis or Pathogenic Atypical Mycobacteria).—With:

A. Positive culture (or positive guinea pig inoculation) of specimen obtained more than 3 months following onset of disability; or

B. Serial X-ray evidence of increasing extent of lesion more than 3 months following onset of disability; or

C. Far-advanced disease with cavitation and positive culture (or positive guinea pig inoculation) of specimen obtained at any time following onset of disability; or

D. Impairment of pulmonary function due to extensive disease should be evaluated under the criteria in §3.02, §3.04, or §3.05.

3.09 Mycotic Infection of Lung.—With:

A. Culture of specific organisms from sputa and serial X-ray evidence or increasing or decreasing extent of lesion, both occurring more than 3 months following onset of disability; or

B. Culture of specific organisms from sputa at any time following onset of disability and current X-ray evidence of a lesion and episodes of hemoptysis occurring at least once every 2 months; or

C. Impairment of pulmonary function due to extensive disease should be evaluated under the criteria in § 3.02, § 3.04, or § 3.05.

3.10 Organic Loss of Speech.—With:

A. Laryngectomy or stenosis of the larynx or paralytic aphonia provided there is inability to produce, by the use of some other anatomical part, speech which can be heard, understood, and sustained; or

B. Central nervous system lesion resulting in severe sensory or motor aphasia paralleling the speech impairment under A above.

3.11 Cor Pulmonale.—With:

A. Congestive heart failure. Evaluate under the criteria in § 4.02; or

B. Right-sided congestive failure as evidenced by peripheral edema and liver enlargement and right ventricular enlargement or outflow tract prominence on X-ray or fluoroscopy.

3.12 Bronchopleural Astula (Persistent).—With empyema.

4.00 Cardiovascular system

A. *Regardless of the cause of heart disease,* disability results from one of two principal consequences of the disease. One is congestive heart failure and the other is ischemia or death of heart muscle. In diseases of the arteries and veins, disability may result from impairment of the vasculature in the central nervous system, eyes, kidneys and extremities. The criteria for evaluating both heart and vascular disorders are expressed in terms of symptoms, signs and laboratory findings.

B. *Congestive heart failure* is considered in the listings under one category regardless of the etiology producing the heart failure (e.g., arteriosclerotic, hypertensive, rheumatic, pulmonary, congenital, or syphilitic heart disease). Congestive heart failure is not considered to be established for the purpose of § 4.02 unless there is evidence at some point in time of signs of vascular congestion such as hepatomegaly, peripheral or pulmonary edema as well as other appropriate findings.

C. *Hypertensive vascular disease* produces disability when it causes complications in one or more of the four main end organs; i.e., the heart, the brain, the kidneys, and the eyes (retinas). This may occur singly or in combination and to varying degrees in the different end organs.

D. *Angina Pectoris.*—The complaint of chest pain, which is considered to be of cardiac origin, must be associated with abnormal laboratory findings. Thus chest pain, by itself, in the absence of corroborative evidence is insufficient to warrant a finding of disability. Angina pectoris, as used herein, is considered to be substernal pain precipitated by effort and relieved by rest or nitroglycerin, described as crushing, squeezing, burning, pressing, or an equivalent thereof. Excluded are sharp, sticking, or rhythmic pains.

E. *Electrocardiographic evidence* is best presented in the form of the actual tracings. Where an electrocardiogram (ECG) is obtained at the expense of the Administration, the tracing must be incorporated in the file. In those cases where an ECG has not been obtained at the expense of the Administration, an interpretation alone is not sufficient and a detailed description of the ECG abnormalities must be given.

When a resting ECG is normal and an ECG exercise test is indicated, it should be performed according to a technique such as the one described in Master, A.M., and Rosenfeld, I.: "Exercise Electrocardiography as an Estimate of Cardiac Function", *Diseases of the Chest,* 51: 347, 1967. The criteria in §4.07 are based upon the Master and Rosenfeld technique and only negative results obtained by the Master and Rosenfeld technique will be used to determine that the criteria in §4.07 are not met. Negative results from techniques other than the Master and Rosenfeld technique are not determinative. However when some other standardized ECG exercise test has been performed, adequately described abnormal test results will be considered equivalent to meeting the criteria described in §4.07. Where the ECG exercise test is obtained at the expense of the Administration, the tracings must be made a part of the file and must be adequately marked as to the lead and duration of time elapsed from performance of the exercise. The report should contain the number of trips indicated, the number of trips actually completed, and the time spent doing the exercise. If the exercise test could not be completed in the required period of time, the circumstances should be described.

F. *Surgical Procedures in Heart Disorders.*—The amount of function restored and the time required to effect improvement in an individual treated by heart surgery varies considerably with the nature and extent of the disorder prior to surgery, the type of surgery involved and many other individual factors. If the criteria described for heart disease are met, proposed heart surgery will not militate against a finding of disability. If insufficient time has elapsed to assess whether impairment of requisite severity persists after surgery, severity of the impairment will be determined by preoperative findings.

4.01 Category of impairments, cardiovascular system

4.02 Congestive heart failure (see § 4.00B) with:

A. Cardio-thoracic ratio of 55 percent or greater, or equivalent enlargement of the transverse diameter of the heart, as shown on teleroentgenogram (6-foot film); or

B. Extension of the cardiac shadow (left ventricle) to the vertebral column on lateral chest roentgenogram and total of S in V_1 or V_2 and R in V_5 or V_6 or more on ECG; or

C. ECG showing QRS duration less than 0.12 second and R of 5 mm. or more in V_1 and R/S of 1.0 or more in V_1 and transition zone (decreasing R/S) left of V_1 with one of the following:

1. Enlargement of the left atrium as evidenced by a double shadow on a PA chest roentgenogram; or

2. Distortion of the barium-filled esophagus.

4.03 Hypertensive Vascular Disease (Apply This Section if Diastolic Pressures Are Consistently in Excess of 100 mm. Hg.)—With:

A. Hypertensive retinopathy evidenced by hemorrhages, or cotton wool patches, with reduction in the caliber of the arterioles and arteriovenous crossing defects (or papilledema); or

B. Impaired renal function as described under the criteria in § 6.02; or

C. Cerebrovascular damage as described under the criteria in § 11.04; or

D. Congestive heart failure as described under the criteria in § 4.02; or

E. Angina pectoris as described under the criteria in § 4.06, § 4.07, or § 4 08.

4.04 Myocardial Infarction Associated With Consistent ECG Abnormalities (or Consistent Abnormalities of Serum Enzymes).—And one of the following:

A. Chest discomfort on effort, relieved by rest or nitroglycerin; or

B. Another documented mycocardial infarction within 6 months following the previous infarction.

4.05 Persistent Heart Block or Recurrent Arrhythmia, as Evidenced by ECG (in Absence of Digitalis) with Cardiac Syncope.

4.06 Angina Pectoris (as Defined in § 4.00D), Associated With Resting ECG Abnormalities, in the Absence of Digitalis (in the Presence of Digitalis, the Predigitalis ECG Should Be Evaluated). Showing one of the following:

A. Depression of the ST segment to more than 0.5 mm. in any of leads I, II, aVL, aVF, V_1 to V_6; or

B. Evaluation of ST segment to 2 mm. or more in any of leads I, II, III, V_4, V_5, or V_6; or

C. Inversion of T-wave to 5.0 mm. or more in any 2 leads except leads III, aVR, V_1 and V_2; or

D. Inversion of T-wave to 1.0 mm. or more in any of leads I, II, aVL, V_2 to V_6 AND R-wave of 5.0 mm. or more in lead aVL and R-wave greater than S-wave in lead aVF; or

E. Second or third degree heart block; or

F. Left bundle branch block as evidence by QRS duration of 0.12 second or more in leads I, II, or III and R peak duration 0.06 second or more (in absence of myocardial infraction) in leads I, AVL, V_5, or V_6.

4.07 Angina Pectoris (as defined in §4 .00D) associated with standardized ECG exercise test abnormalities (see § 4.00E) in the absence of digtalis (in the presence of digitalis, the predigitalis ECG should be evaluated), showing one of the following:

A. Development of depression of ST segment to more than 0.5 mm. which lasts for at least 0.12 seconds and appears in at least 2 consecutive complexes in any leads; or

B. Development of bundle branch block.

4.08 Chest Discomfort on Effort Relieved by Rest or Nitroglycerin.—With:

A. Obstruction or narrowing of coronary vessels observed on angiography obtained independent of social security disability evaluation; or

B. Heart enlargement as described under the criteria in § 4.02.

4.09 Rheumatic or Syphilitic Heart Diesease.—With:

A. Congestive heart failure as described under the criteria in § 4.02; or

B. Chest discomfort on effort relieved by rest or nitroglycerin as described under the criteria in § 4.08; or

C. Chest dicsomfort on effort, relieved by rest or nitroglycerin, and one of the ECG anbormalities described under the criteria in § 4.06 or § 4.07; or

D. Heart block or recurrent arrhythmias as described under the criteria in § 4.05; or

E. Cerebrovascular damage as described under the criteria in §11.04.

4.10 Corpulmonale.—With:

A. Heart enlargement as described under the criteria in § 4.02; or

B. Right sided congestive failure as evidenced by peripheral edema and liver enlargement and right ventricular enlargement, or outflow tract prominence, on X-ray or fluroscopy.

4.11 Aneurysm of Aorta or Branches (Demonstrated by X-Ray Evidence).—With:

A. Congestive heart failure as described under the criteria in § 4.02; or

B. Chest discomfort (with or without effort); or

C. Repeated bleeding due to aneurysmal erosion; or

D. Syncope.

4.12 Chronic Venous Insufficiency, Lower Extremity.—With chronic obstruction of the deep venous return, superficial varicosities, recurrent ulceration, and extensive brawny edema.

4.13 Arteriosclerosis Obliterans or Thrombo-Angiitis Obliterans.—With:

A. Intermittent claudication with absence of peripheral arterial pulsations below the femoral artery or failure of visualization of a major peripheral artery on arteriogram; or

B. Amputation at or above the tarsal region due to peripheral vascular disease.

5.00 Digestive system

A. *Diseases and disorders of the digestive system* resulting in disability usually do so because of interference with nutrition, multiple recurrent inflammatory lesions, or complications of disease; such as, fistulae, abscesses, or recurrent obstruction.

B. *Malnutrition or Weight Loss From Gastro-Intestinal Disorders.*—When the primary disorder of the digestive tract has been established (e.g., intero-colitis, chronic pancreatitis, post gastrointestinal resection, etc.), the resultant interference with nutrition will be considered under the criteria in § 5.08. This will apply whether the weight loss is due to a primary or secondary malabsorption or malassimilation syndrome or due to decreased caloric intake. However, weight loss not due to disease of the digestive tract but associated with psychiatric disorders should be evaluated under the appropriate listing for the underlying psychiatric disorder.

C. A colostomy or ileostomy does not impose marked restriction of activity if the individual is able to maintain adequate nutrition and function of the stoma.

5.01 Category of impairment, digestive system

5.02 Loss of Tongue (Whole or Part).—With:

A. Weight loss or malnutrition as described under the criteria in § 5.08; or

B. Inability to communicate by speech.

5.03 Stricture, Stenosis, or Obstruction of the Esophagus (Demonstrated by X-Ray or Endoscopy).—With weight loss or malnutrition as described under the criteria in § 5.08.

5.04 Peptic Ulcer Including Residuals or Complications (Demonstrated by X-Ray).—With:

A. Postoperative recurrent ulceration; or

B. Fistula formation; or

C. Recurrent obstruction demonstrated by X-ray; or

D. Weight loss or malnutrition as described under the criteria in § 5.08.

5.05 Cirrhosis of Liver.—With:

A. Ascites, not attributable to other causes, which has been demonstrated by abdominal paracentesis or is associated with serum albumin or 3.0 Gm./100 ml. or less; or

B. Serum bilrubin of 2.5 mg./100 ml. or greater or bile in urine (either finding on repeated examinations); or

C. Esophageal varices, demonstrated by X-ray or endoscopy, with a documented history of bleeding attributed to these varices or performance of either a shunt operation or application of varices; or

D. Hepatic coma documented by findings from hospital records.

5.06 Ulcerative Colitis (Demonstrated by Endoscopy or Barium Enema Study).—With:

A. Recurrent bloody stools on repeated examinations and complicated by systemic manifestations; e.g., arthritis, iritis, recurrent fever, or jaundice; or

B. Bowel perforation with abscess or fistula formation; or

C. Recurrent enteritis after total colectomy; or

D. Weight loss or malnutrition as described under the criteria in § 5.08.

5.07 Regional Enteritis (Demonstrated by Operative Findings or Small Bowel Study).—With:

A. Partial intestinal obstruction; or

B. Abscess or fistula formation; or

C. Weight loss or malnutrition as described under the criteria in §5.08.

5.08 Malnutrition (Caused by a Gastro-Intestinal Impairment Resulting From Malabsorption, Malassimilation, or Decreased Caloric Intake).—With:

A. Weight equal to or less than the values specified in Tables I or II; or

B. Weight greater than the values specified in Tables I or II but equal to or less than the values specified in Tables III or IV and one of the following abnormal test findings:

1. Fat in stool of 7 Gm. or greater per 24-hour stool specimen or decreased absorption of radioactive iodine-labeled fat; or

2. Nitrogen in stool of 3 Gm. or greater per 24-hour stool specimen or decreased absorption of radioactive labeled protein; or

3. Abnormally low D-xylose tolerance test in absence of impaired renal function; or

4. Serum carotene of 45 mcg./100 ml. or less; or

5. Serum calcium of 8.5 mg./100 ml. or less; or

6. Serum albumin of 3.0 Gm./100 ml. or less; or

7. Hematocrit of 34 percent or below in males or 30 percent or below in females.

Tables of weight reflecting malnutrition scaled according to height and sex—to be used only in connection with §5.08.

Table I—Men

Height (in.) [1]	*Weight (lbs.)*	*Height (in.)* [1]	*Weight (lbs.)*
61	90	69	112
62	92	70	115
63	94	71	118
64	97	72	122
65	99	73	125
66	102	74	128
67	106	75	131
68	109	76	134

Table II—Women

Height (in.) [1]	*Weight (lbs.)*	*Height (in.)* [1]	*Weight (lbs.)*
58	77	66	98
59	79	67	101
60	82	68	104
61	84	69	107
62	86	70	110
63	89	71	114
64	91	72	117
65	94	73	120

Table III—Men

Height (in.) [1]	*Weight (lbs.)*	*Height (in.)* [1]	*Weight (lbs.)*
61	95	69	119
62	98	70	122
63	100	71	126
64	103	72	129
65	106	73	133
66	109	74	136
67	112	75	139
68	116	76	143

Table IV—Women

Height (in.) [1]	Weight (lbs.)	Height (in.) [1]	Weight (lbs.)
58	82	66	104
59	84	67	107
60	87	68	111
61	89	69	114
62	92	70	117
63	94	71	121
64	97	72	124
65	100	73	128

[1] Height measured without shoes.

6.00 *Genito-urinary system*

A. *Cardiac or other complications* associated with renal disorders may be evaluated according to the appropriate body system listing.

B. *Permanent Urinary Diversion.*—It may be necessary to permanently alter the normal course of outflow of urine when disease or trauma destroys portions of the urinary tract. In these cases, evaluation should take into consideration the underlying medical condition as well as the method used in establishing urinary diversion. Significant complications that might result after permanent urinary diversion are in the area of renal impairment such as progressive hydronephrosis.

6.01 *Category of impairments, genito-urinary system*

6.02 Impairment of Renal Function, Due to Any Cause (e.g., Hypertensive Vascular Disease, Nephritis, Nephrolithiasis, Polycystic Disease, Ureteral Obstruction, etc.).—With repeated abnormal renal function tests showing:

A. BUN of 30 mg./100 ml. or greater (or equivalent elevation of NPN, blood urea, or creatinine); or

B. Creatine clearance equal to or less than 60 liters/24 hours (42 ml./min.).

6.03 Removal or Functional Loss of One Kidney.—Evaluate existing diesase in the remaining kidney under the criteria in § 6.02.

6.04 Permanent Urinary Diversion (e.g., Suprapublc Cystostomy (Uretero-Interstinal Diverson, Cutaneous Ureterostomy, etc.).—With progressive bilateral hydronephrosis.

6.05 Tuberculosis of the Genito-Urinary Tract.—With:

A. Positive culture of M. Tuberculosis more than 3 months following onset of disability; or

B. Increasing extent of lesion on cystoscopy or serial pyelography more than 3 months following onset of disability.

7.00 *Hemic and lymphatic system*

A. *Cause of Disability.*—Disability based upon anemia results from inadequate oxygenation of tissues caused by a reduction of the oxygen-carrying capacity of the blood. Hematologic defects can also result in defective hemostatic mechanisms with hemorrhage into such functional components as the brain or major joints or thrombosis of the vascular supply of vital organs. Formation of tumors may cause compression of vital structures or erosion of bone. Deposits of breakdown products of the blood cells may cause impairment of hepatic or renal function, joint deformity, or formation of cholelithiasis with subsequent bile duct obstruction. Where involvement of other organ systems has occurred as a result of hematologic disease, these impairments should be evaluated under the criteria for the appropriate sections.

Red blood cells may be replaced by blood transfusion, but in some diseases this elevation of hematocrit is only transient. A contemplated splenectomy should not, in itself, militate against a finding of disability expected to last at least 12 months.

The level of laboratory findings cited in the categories; i.e., hematocrit, serum bilirubin, reticulocyte and blood platelet count, should reflect the values reported on more than one examination. A single laboratory finding will not suffice to meet the level described.

7.01 Category of impairments, hemic and lymphatic system

7.02 Chronic Anemia (Manifested by Hematocrit of 30 Percent or Less).—Evaluate the resulting impairment or the primary disorder under the criteria for the affected body system.

7.03 Hemolytic Anemia (Due to Any Cause.)—Manifested by hematocrit of 30 percent or less with:

A. Serum bilirubin of 1.5 mg./100 ml. or greater; or

B. Reticulocyte count of 4 percent or greater.

7.04 Paroxysmal Nocturnal Hemoglobinuria.—With hematocrit of 30 percent or less and persistent hemolysis or recurrent crisis.

7.05 Hemoglobinopathies (e.g. Sickle Cell Disease, Thalassemia).—With hematocrit of 30 percent or less and at least one major hemolytic crisis within the 6 months following the onset of disability with a further recorded drop in hematocrit.

7.06 Purpuras (e.g., Idiopathic Thrombocytopenic Purpuras).—With:

A. Persistent purpura and at least one major spontaneous hemorrhage from a body orifice within the 6 months following the onset of disability; or

B. Blood platelet count of 40,000/cu. mm. or less.

7.07 Hereditary Telangiectasia.—With frequent major hemorrhages from body orifices.

7.08 Coagulation Defects (e.g., Deficiency of Antihemophilic Factor(AHF), Plasma Thromboplastic Component (PTC), Plasma Thromboplastin Antecedent (PTA) or of Fibrinogen).—With frequent episodes of spontaneous hemorrhage and hemarthrosis of one major joint with deformity.

7.09 Polycythemia (Secondary and Primary Manifested by Hematocrit of 55 Percent or More in Males or 50 Percent or More in Females).—Evaluate the resulting impairment under the criteria for the affected body system.

7.10 Chronic Bone Marrow Failure (Aplastic Anemia, Myelofibrosis, Myeloid Metaplasia, Myelopthisic Anemia, etc.).—With:

A. Persistant hematocrit 30 percent or less; or

B. Recurrent hemorrhagic manifestations; or

C. Blood platelet count of 40,000/cu. mm. or less; or

D. Spleen enlarged to iliac crest.

7.11 Acute Leukemias.—With appropriate findings on peripheral blood smear or bone marrow examination.

7.12 Chronic Leukemias.—With:

A. Persistent of 30 percent or less; or

B. Recurrent hemorrhagic manufestations; or

C. Blood platelet count of 40,000/cu. mm. or less; or

D. Massive organ enlargement (e.g., nodes, spleen, or liver) unreduced by prescribed therapy; or

E. Recurrent fever (100° F. or above orally).

7.13 Lymphomas and Multiple Myeloma.—Evaluate under the criteria for neoplastic diseases in §13.00.

7.14 Macroglobulinemia (Diagnosis Confirmed by Ultracentrifugation or Immunoelectrophoresis).—With frequent hemorrhages from body orifices.

8.00 Skin

Conditions of the skin, including disfiguring scars and repugnant skin disease, will not ordinarily be found in themselves to be disabling. Some skin conditions such as the ulcerations and eczemas associated with severe varicose veins, or the disfiguring and repugnant skin lesions of certain types of dermatitis, are significant as manifestations of the underlying condition. Large areas of skin surface are sometimes destroyed by severe burns with consequent scarring and disfigurement. Eventually, factors of contractures and deformities play a significant role in determining functional capacities, and these, in turn, should be evaluated under the criteria in the Musculoskeletal System. (§1.00 ff.)

8.01 Category of impairments, the skin

8.02 Exfoliative Dermatitis (Generalized).—In grave and protractive types.

8.03 Pemphigus.—Evaluate under the criteria in § 8.02.

9.00 *Endocrine system.*

Cause of Disability.—Disability is caused by overproduction or underproduction of hormones resulting in structural and/or functional changes in the body. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

9.01 *Category of impairments, endocrine*

9.02 Thyroid Disorders.—With:

A. Progressive exophthalmos as measured by exophthalmometry; or

B. Evaluate the resulting impairment under the criteria for the affected body system.

9.03 Hyperparathyroidism.—With:

A. Generalized decalcification of bone on X-ray study and elevation of plasma calcium to 11 mg./100 ml. or greater; or

B. Evaluate the resulting impairment according to the listing under the affected body system.

9.04 Hypoparathyroidism.—With:

A. Severe recurrent tetany; or

B. Recurrent generalized convulsions; or

C. Evaluate lenticular cataracts under the criteria in § 2.00 ff.

9.05 Neurohypophyseal Insufficiency (*Diabetes Insipidus*).—With persistent urine specific gravity of 1.005 or below and dehydration.

9.06 Hyperfunction of the Adrenal Cortex.—Evaluate the resulting impairment under the criteria for the affected body system.

9.07 Adrenal Cortical Insufficiency (*Addison's Disease*).—With recurrent episodes of circulatory collapse manifested by hypotensive episodes.

9.08 Diabetes Mellitus.—A. When diabetes exists with other physical or mental impairments, evaluate under the criteria for the appropriate body systems; or

B. Diabetes with one of the following (not covered under the existing body system listing):

1. Neuropathy with moderate motor deficit in two extremities; or
2. Acidosis occuring at least on the average of once every two months, documented by appropriate blood chemical tests (pH or pCO^2 or bicarbonate levels); or
3. Amputation at, or above, the tarsal region due to diabetic necrosis or peripheral vascular disease; or
4. Ophthalmologic findings of:
    a. Retinitis proliferans; or
    b. Rubeosis iridis; or
    c. Venous distention and capillary pattern distortion with hemorrhages or exudates.

10.00 *Multiple body systems*

Introduction.—The impairments included in this section usually involve more than a single body system. For the categories of miliary tuberculosis and tuberculous adenitis, the existence of tubercle bacilli must be established in accordance with the criteria in §3.00B.

10.01 *Category of impairments, multiple body systems*

10.02 Hansen's Disease (*Leprosy*).—As active disease or consider as "under a disability" while hospitalized.

10.03 Polyarteritis or Periarteritis Nodosa (*Established by Biopsy*).—With signs of generalized arterial involvement.

10.04 Disseminated Lupus Erythematosus (*Established by a Positive LE Preparation or Biopsy*).—With frequent exacerbations demonstrating involvement of renal or cardiac or pulmonary or gastrointestinal or central nervous systems.

10.05 Scleroderma or Progressive Systemic Sclerosis (*the Diffuse or Generalized Form*).—With:

A. Advanced limitation of use of hands due to sclerodactylia or limitation in other joints; or

B. Visceral manifestations of digestive, cardiac, or pulmonary impairment.

10.06 Miliary Tuberculosis.—With:

A. Demonstration of tubercle bacilli—more than 3 months following the onset of disability; or

B. Evaluate the residual impairment under the criteria for the affected body system.

10.07 Tuberculous Adenitis.—With:

A. Demonstration of tubercle bacilli more than 3 months following the onset of disability; or

B. Other evidence of increasing extent of lesion more than 3 months following the onset of disability.

11.00 Neurological.

A. *Epilepsy.*—Epilepsy must be substantiated by at least one detailed description of a typical seizure, preferably one observed and reported by a physician. Testimony of reliable lay persons may be acceptable for description of seizures only if professional observation is not available. Documentation of epilepsy should include an electroencephalogram (EEG). The severity of the impairment will be determined according to the frequency, duration, and sequelae of seizures. Where adequate seizure control is obtained only with unusually large doses of medication, consideration will be given to any imapirment resulting from the side effects of this medication.

B. *Brain Tumors.*—The diagnosis in malignant brain tumor should be established under the criteria described in § 13.00B, for Neoplastic Diseases.

1101. Category of impairment, neurological

11.02 Epilepsy—Major Motor Seizures (Grand Mal or Psychomotor) Substantiated by EEG, Occurring More Frequently Than Once a Month in Spite of Prescribed Treatment.—With:

A. Diurnal episodes (loss of consciousness and convulsive seizure); or

B. Nocturnal episodes which show residuals interfering with activity during the day.

11.03 Epilepsy—Minor Motor Seizures (Petit Mal or Psychomotor) Substantiated by EEG, Occurring more Frequently Than Once Weekly in Spite of Prescribed Treatment.—With:

A. Alteration of awareness or loss of consciousness; and

B. Transient postictal manifestations of unconventional or antisocial behavior.

11.04 Cerebrovascular Accident.—With one of the following more than 4 months Post-CVA:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Pseudobulbar palsy; or

C. Moderate motor deficit in two extremities; or

D. Ataxia affecting two extremities substantiated by approrpate cerebellar signs or proprioceptive loss.

11.05 Brain Tumors.—A. Malignant gliomas (astrocytoma—Grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, or primary sarcoma; or

B. Evaluate astrocytoma (Grades I and II), pituitary tumors, oligodendroglioma, ependynoma, clivus chordoma, and benign tumors under the criteria in § 11.02, § 11.03, or § 11.04A, C or D.

11.06 Paralysis Agitans (Parkinson's Disease). With tremor, rigidity, and impairment of mobility (e.g., festination).

11.07 Cerebral Palsy.—With:

A. IQ of 69 or less; or

B. Abnormal behavior patterns, such as destructiveness or emotional instability; or

C. Significant interference in communication due to speech, hearing, or visual defect; or

D. Moderate motor deficit in two extremities.

11.08 Spinal Cord Lesions, Due to Any Cause.—With moderate motor loss in two extremities.

11.09 Multiple Sclerosis.—With:

A. Moderate motor deficits in two extremities; or

B. Ataxia substantiated by appropriate cerebellar signs or proprioceptive loss.

11.10 Amyotrophic Lateral Sclerosis or Syringomyelia.—With:

A. Bulbar signs; or

B. Moderate motor (or sensory, if applicable) deficit in two extremities.

11.11 Anterior Poliomyelitis.—With:

A. Flexion contractures as described under the criteria in § 1.09; or

B. Respiratory distress or dysphagia; or

C. Moderate motor weakness in two extremities.

11.12 Myasthenia Gravis.—With:

A. Difficulty in speaking or swallowing while on prescribed therapy; or

B. Motor weakness of muscles of extremities on restrictive activity against resistance while on prescribed therapy.

11.13 Muscular Dystrophy.—With:

A. Waddling or incoordinate gait; or

B. Flexion deformities of both lower extremities; or

C. Weakness or paralysis of muscles of shoulder girdle or of neck, with abduction of both arms at shoulder restricted to less than 90 degrees.

11.14 Peripheral Neuropathies.—With moderate motor deficit in two extremities.

11.15 Tabes Dorsalis.—With:

A. Tabetic crises occurring more frequently than once monthly; or

B. Unsteady, broad-based, or ataxic gait substantiated by appropriate posterior column signs; or

C. Charcot joint as described under the criteria in §1.03.

11.16 Subacute Combined Cord Degeneration (Pernicious Anemia).—With:

A. Moderate motor deficit in two extremities; or

B. Unsteady, broad-based, or ataxic gait substantiated by appropriate posterior column signs.

11.17 Degenerative Disease (Huntington's Chorea, Friedreich's Ataxia, Spino-Cerebellar Degenerations).

12.00 Mental disorders

Introduction.—For the purpose of the social security program, mental disorders will be considered in three group entities; organic brain syndromes, functional disorders, and mental deficiency.

DISCUSSION OF MENTAL DISORDERS

A. *Organic brain syndromes* are disorders caused by, or associated with, impairment of brain tissue.

Acute brain syndromes are mentioned for explanatory purposes only since their duration is too short to assume adjudicative significance. They are temporary and reversible conditions with favorable prognosis and no significant residuals. They are short-lived and self-limited. Occasionally, an acute brain syndrome may progress into a chronic brain syndrome.

Chronic brain syndromes result from persistent, more or less irreversible diffuse impairment of cerebral tissue function. They are usually permanent and may be progressive. They may be accompanied by psychotic or neurotic reactions superimposed on the organic brain pathology. The degree of impairment may range from mild to severe.

The individual's personal appearance and behavior at the time of the examination, his daily activities, interests, and habits generally reflect the severity of the impairment and are, therefore, very important in the evaluation process.

B. *Functional mental disorders* are characterized by demonstrable mental abnormalities without demonstrable structural changes in the brain tissue.

Psychotic Disorders.—Mood disorders (involutional psychotic, manic-depressive, psychotic depressive reactions) and thought disorders (schizophrenic and paranoid reactions) are characterized by varying degrees of personality disorganization and accompanied by a corresponsing degree of inability to maintain contact with reality (e.g., hallucinations, delusions).

Nonpsychotic disorders (psychophysiologic, psychoneurotic and personality disorders).

Psychophysiologic autonomic and visceral disorders (e.g., cardiovascular, gastrointestinal, genitourinary, musculoskeletal, respiratory). In these disorders, the normal physiological expression of emotions is exaggerated by chronic emotional tensions, eventually leading to a disruption of the autonomic regulatory system, resulting in various visceral disorders. If the condition persists, it may lead to demonstrable structural changes (e.g., peptic ulcer, bronchial asthma, dermatitis).

Psychoneurotic disorders (anxiety reaction, neurotic-depressive reaction, conversion reaction, dissociative reaction, obsessive-compulsive reaction, phobias). There are no gross falsifications of reality such as observed in the psychoses in the form of hallucinations or delusions. Psychoneuroses are characterized by reactions to deep-seated conflicts and are classified by the defense mechanisms the individual employs to stave off the threat of emotional decompensation (e.g., anxiety, depression, conversion, obsessive-compulsive or phobic mechanisms). Anxiety or depression occurring in connection with overwhelming external situations (i.e., situational reactions) are self-limited, and the symptoms generally recede when the situational stress diminishes.

Personality disorders (inadequate, schizoid, cyclothymic, paranoid personalities, emotional instability, passive-aggressive and passive-dependent behavior; compulsive personality; antisocial behavior, sexual deviations, addiction). These disorders or defects in personality structure are often characterized by lifelong patterns of inadequate or socially unacceptable behavior.

C. *Mental deficiency* denotes a lifelong disorder characterized by below-average intellectual endowment as measured by standard intelligence (IQ) tests and associated with impairment in one or more of the following areas: learning, malnutrition, and social adjustment.

The following paragraphs discuss evidence required in cases involving mental deficiency:

1. In mental deficiency, the degree of impairment should be determined primarily on the basis of the IQ and the medical report. Intelligence tests should be administered and interpreted by a qualified psychologist or psychiatrist using standardized intelligence tests such as the Wechsler Adult Intelligence Scale (WAIS). In special circumstances, nonverbal performance tests, such as the Raven Progressive Matrices or the Arthur Point Scale, may be substituted. However, identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual function. Therefore it may be necessary to convert the IQ to the percentile rank of the general population in order to determine the actual degree of impairment reflected by the IQ score. In communities where a qualified psychologist or psychiatrist is not readily available, an intelligence test administered by a vocational rehabilitation counselor or a specially trained person associated with a local school system may be accepted, particularly when other findings are also consistent with extremely low intellectual capacity.

2. In cases where, in the opinion of the psychological examiner, the nature of the individual's performance is such that testing, as described above, is precluded or cannot otherwise be obtained, medical reports specifically describing the level of intellectual, social, and physical functions should be obtained. Actual observations by district office or State agency personnel, reports from educational institutions, information furnished by public welfare agencies or other reliable, objective sources should be considered as additional evidence.

D. *Documentation.*—The severity of a mental disorder should be evaluated on the basis of psychiatrists' reports, hospital reports, psychologists' reports, and descriptions of daily activities.

Confinement in an institution does not establish that an impairment is severe. Also, release from an institution does not establish improvement. The severity and duration of the impairment is determined by the medical evidence.

In some cases, the results of standard psychological tests, such as the Wechesler Adult Intelligence Scale (WAIS) and the Minnesota Multiphasic Personality Inventory (MMPI), may be of considerable value in making a differential diagnosis and in establishing the severity of the impairment. To provide full documentation, the psychological report should include key data on which the report was based, such as MMPI profiles, WAIS subtest scores, etc.

12.01 Category of impairments, mental

12.02 Chronic Brain Syndromes.—Documented by mental status examination (supported, if necessary, by the results of appropriate, standardized psychological tests) establishing deterioration in intellectual functioning and manifested by marked restriction of daily activities and contriction of interests and deterioration in personal habits and seriously impaired ability to relate to other people and persistence of one of the following:

A. Marked memory defect for recent events; or

B. Impoverished, slowed, perseverative thinking, with confusion or disorientation; or

C. Labile, shallow, or coarse affect.

12.03 Functional Psychotic Disorders (Mood Disorders, Schizophrenic Reactions, Paranoid Reactions).—Manifested by marked restrictions of daily activities and constriction of interests and seriously impaired ability to relate to other people, and persistence of one of the following:

A. Depression (or elation); or

B. Agitation; or

C. Psychomotor disturbances: or

D. Hallucinations or delusions; or

E. Autistic or other regressive behavior; or

F. Inappropriateness of affect; or

G. Illogical association of ideas.

12.04 Functional Nonpsychotic Disorders (Psychophysiologic, Psychoneurotic and Personality Disorders).—Manifested by marked restriction of daily activities and constriction of interests and deterioration in personal habits and seriously impaired ability to relate to other people and persistence of one of the following:

A. Demonstrable structural changes mediated through psychophysiological channels (e.g., duodenal ulcer); or

B. Recurrent and persistent periods of anxiety, with tension, apprehension, and interference with concentration and memory; or

C. Persistent depressive affect with insomnia, loss of weight, and suicidal ideation; or

D. Phobic or obsessive ruminations with inappropriate, bizarre or disruptive behavior; or

E. Compulsive, ritualistic behavior; or

F. Persistent functional disturbance of vision, speech, hearing or use of a limb with demonstrable structural or trophic changes; or

G. Life-long, habitual, and inappropriate patterns of behavior manifested by one of the following:

1. Seclusiveness and autistic thinking; or

2. Antisocial or amoral behavior (including pathologic sexuality) manifested by: (a) inability to learn from experience and inability to conform with accepted social standards, leading to repeated conflicts with society or authority and (b) by psychopathology documented by mental status examination and the results of appropriate, standardized psychological tests; or

3. Addictive dependence on alcohol, or drugs, with evidence of irreversible organ damage; or

4. Pathologically inappropriate suspiciousness or hostility manifested by psychopathology documented by mental status examination and the results of appropriate, standardized psychological tests.

12.05 Mental Deficiency.—As manifested by:

A. Severe mental and social incapacity as evidenced by marked dependence upon others for personal needs (e.g., bathing, washing, dressing, etc.) and inability to understand the spoken word and inability to avoid physical danger (fire, cars, etc.) and inability to follow simple directions and inability to read, write, and perform simple calculations; or

B. IQ of 49 or less (see § 12.00C1); or

C. IQ of 50 to 69, inclusive (see § 12.00C1) and:

1. Inability to perform routine, repetitive tasks; or

2. A physical or other mental impairment resulting a restriction of function.

13.00 Neoplastic diseases—malignant

A. *Introduction.*—The determination of the level of severity resulting from cancer is made from a consideration of the site of the lesion, the histogenesis of the tumor, the extent of involvement, the apparent adequacy and response to therapy (surgery, irradiation, hormones, chemotherapy), and the magnitude of the posttherapeutic residuals.

Significant posttherapeutic residuals, not specifically included in the category of impairments for malignant neoplasms, should be evaluated according to the affected body system.

B. *Documentation.*—The diagnosis of cancer should be established on the basis of symptoms, signs and laboratory findings. The site of the primary, recurrent and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen. The evidence should include also a recent report directed especially at revealing evidence of local or regional recurrence, soft part or skeletal metastasis and significant post-therapeutic residuals.

C. *Evaluation.*—Usually, when the cancer consists only of a local lesion with metastasis to the regional lymph nodes which apparently has been completely excised, imminent recurrence or metastasis is not anticipated. Exceptions are noted in sections 13.03, 13.05B, 13.09D, 13.10A, 13.11A–F, 13.17C, 13.22A–B, and 13.24A.

Local or regional recurrence after radical surgery or pathological evidence of incomplete excision by radical surgery are to be equated with unresectable lesions and, for the purpose of our program may be evaluated as "inoperable." These situations are usually followed by severe impairment within 6 months to 1 year. A severe impairment may usually be determined to exist, because the curtailment of activities is imminent.

Local or regional recurrence after incomplete excision of a localized, completely resectable tumor is not to be equated with recurrence after radical surgery.

When a cancer has metastasized beyond the regional lymph nodes the impairment is severe and usually terminates fatally within a short time despite palliative therapy. Exceptions are partially hormone-dependent tumors; isotope-sensitive metastases; or remote metastases which have not been apparent for 5 or more years.

13.01 Category of impairments, neoplastic diseases—Malignant

13.02 Epidermoid Carcinoma (Including Lympho-Epithelioma of Base of Tongue, Pharynx and Tonsil).—A. Inoperable or recurrent after radical surgery; or

B. Remote metastasis.

13.03 Sarcoma of Skin—Angiosarcoma or Mycosis Fungoides With Metastasis to Regional Lymph Nodes or Beyond.

13.04 Sarcoma of Soft Parts.—A. Not controlled by prescribed therapy; or

B. Cellular sarcoma with remote metastasis.

13.05 Malignant Melanoma.—A. Recurrent after excision; or

B. With metastasis to adjacent skin or regional lymph nodes or elsewhere.

13.06 Lymph Nodes.—A. Hodgkins disease, lymphosarcoma or giant follicular lymphoblastoma—not controlled by prescribed therapy or with evidence of mediastinal, pelvic, abdominal, retroperitoneal or skeletal extension from peripheral lymph nodes; or

B. Metastasis from distant carcinoma; or

C. Lymph nodes site of unresectable carcinoma.

13.07 Salivary Glands—Carcinoma or Sarcoma With Metastasis Beyond the Regional Lymph Nodes.

13.08 Thyroid Gland—Carcinoma With Metastasis Beyond the Regional Lymph Nodes Not Controlled by Prescribed Therapy.

13.09 Breast.—A. Inoperable carcinoma including acute (inflammatory) carcinoma; or

B. Recurrent carcinoma; or

C. Remote metastasis from breast carcinoma. (Bilateral breast carcinoma, synchronous or metachronous, is usually primary in each breast); or

D. Sarcoma with metastasis anywhere.

13.10 Skeletal System (Exclusive of the Jaw).—A. Osteogenic sarcoma, Ewing's tumor, reticulum cell sarcoma with evidence of metastasis; or

B. Multiple or diffuse myeloma; or

C Metastatic carcinoma to bone (except those originating in thyroid or prostate evaluate under the criteria in §13.08 or §13.23).

13.11 Mandible, Maxilla, Orbit, or Temporal Fossa.—A. Sarcoma of any type with metastasis; or

B. Carcinoma of the antrum with extension into the orbit, or ethmoid or sphenoid sinus, or with regional or remote metastasis; or

C. Orbital tumors with intracranial extension; or

D. Tumors of the emporal fossa with perforation of skull and meningeal involvement; or

E. Adamantinoma with orbital or intracranial infiltration; or

F. Tumors of Rathke's pouch with infiltration of the base of the skull or bilateral metastasis to the cervical lymph nodes or remote metastasis.

13.12 Brain or Spinal Cord.—A. Metastatic carcinoma to brain or spinal cord.

B. Evaluate other tumors under the criteria described in §11.05 and §11.08.

13.13 Lungs—Bronchogenic Carcinoma or Adenocarcinoma.—A. Unresectable; or

B. Recurrent after resection; or

C. Incomplete excision; or

D. Infiltration of the chest wall or preoperative pleural effusion or remote metastasis; or

E. Metastatic carcinoma or sarcoma to the lungs (except metastasis from thyroid, evaluate under the criteria in §13.08).

13.14 Pleura or Mediastinum.—A. *Pleural* mesothelioma, with pleural effusion or remote metastasis; or

B. All primary or metastatic tumors of the anterior mediastinum (except thyroid or parathyroid tumors and benign thymoma and primary Hodgkins disease); or

C. Metastatic carcinoma or sarcoma to the pleura or mediastinum (except metastasis from thyroid, evaluate under the criteria in §13.08).

13.15 Abdomen.—A. Generalized carcinomatosis; or

B. Retroperitoneal cellular sarcoma; or

C. Unresectable benign fibromyxoma of nerve sheath.

13.16 Esophagus or Stomach.—A. Carcinoma or sarcoma of the upper two-thirds of the esophagus; or

B. Carcinoma or sarcoma, of the distal one-third of the esophagus with metastasis beyond the regional lymph nodes; or

C. Carcinoma of the stomach with either metastasis beyond the regional lymph nodes or extension into the colon, pancrease or liver, or

D. Inoperable carcinoma; or

E. Recurrence or metastasis after resection; or

F. Multiple sarcomas.

13.17 Small Intestine.—A. Carcinoma or carcinoid tumor with metastasis beyond the regional lymph nodes; or

B. Multiple sarcomas; or

C. Sarcoma with metastasis.

13.18 Large Intestine (From Ileocecal Valve to and including Anal Canal)—Carcinoma or Sarcoma.—A. Unresectable; or

B. Metastasis beyond the regional lymph nodes; or

C. Recurrence, or remote metastasis, after resection.

13.19 Liver or Gallbladder.—A. Primary or metastatic carcinoma, carcinoid tumor or sarcoma of the liver; or

B. Carcinoma of the gallbladder or bile duct when unresectable or there is direct extension into the liver.

13.20 Pancreas.—Carcinoma in any location.

13.21 Kidneys, Adrenal Glands, or Ureters—Carcinoma.—A. Unresectable or with metastasis; or

B. Metastatic carcinoma to a kidney, adrenal gland, or ureter.

13.22 Urinary Bladder—Carcinoma.—With:

A. Infiltration beyond the bladder wall; or
B. Metastasis; or
C. Unresectable; or
D. Recurrence after total cystectomy; or
E. Evaluate urinary diversion after total systectomy under the criteria in § 6.04.

13.23 Prostate Gland.—Carcinoma not controlled by prescribed therapy.

13.24 Testicles.—A. Choriocarcinoma with metastasis even to regional lymph nodes; or

B. Other malignant tumors with metastasis beyond the para-aortic lymph nodes or when metastasis to the para-aortic lymph nodes are unresectable or not controlled by prescribed therapy.

13.25 Uterus—Carcinoma or Sarcoma (Fundus or Cervix).—A. Inoperable and not controlled by prescribed therapy; or

B. Recurrent, after total hysterectomy; or
C. Total pelvic exenteration.

13.26 Ovary or Fallopian Tubes—All Malignant Primary or Recurrent Tumors.—With:

A. Ascites; or
B. Unresectable infiltration; or
C. Unresectable metastasis to omentum or elsewhere in the peritoneal cavity; or
D. Remote metastasis; or
E. All metastatic tumors to ovary or Fallopian tubes.

13.27 Leukemia.—Evaluate under the criteria in § 7.00 ff, Hemic and Lymphatic System.

8. Earnings Level and Substantial Gainful Activity

Staff question: ***The earnings levels which are used to show ability to engage in substantial gainful activity (SGA) used to be geared to the amount used for the earnings test for retirement purposes. When was this changed and what was the rationale for the change? Are the present amounts reasonable, since they have been in effect for a number of years?***

Historically the SGA test and the retirement test amounts have coincided. Thus, from the beginning of the disability program until last year the SGA earnings level has been identical with the retirement test exempt amount. This has had important administrative and public information advantages. Confusion and misunderstanding have been avoided and we have not been obliged to distinguish between the two amounts for beneficiaries to understand the levels of earnings affecting the continued receipt of benefits. However, we have always carefully avoided any suggestion or rationale to the effect that the SGA level is the same as the retirement test exempt amount. They are separate tests, which serve different purposes, and the earnings level for each is independently established. The SGA earnings level is based on the average earnings of workers in private employment and is adjusted in accordance with changes in average hourly wages in non-agricultural employment and average yearly earnings.

The dollar amounts now in the disability regulations were established in 1968. Due to changes in the economy, we have under consideration a proposed change in regulations that would substantially increase the substantial gainful activity earnings level for both the title II and title XVI programs. While new dollar amounts have not been determined as of this time, our intention is to restore the general balance that formerly existed between the SGA level and the earnings received by unimparied workers in private employment.

EXCERPT FROM DISABILITY REGULATIONS [1]

404.1532 Evaluation of work activities

(*a*) *In General.*—If an individual performed work during any period in which he alleges that he was under a disability as defined in § 404.1501, the work performed may demonstrate that such individual has ability to engage in substantial gainful activity. If the work performed establishes that an individual who is not statutorily blind is able to engage in substantial gainful activity, he is not under a disability. (For the statutorily blind, see paragraph (*g*) of this section.) Work which does not in itself constitute substantial gainful activity, may nevertheless indicate the existence of a residual capacity of such individual to engage in substantial gainful activity. Thus, an individual who utilizes work skills or abilities on a limited basis may not be under a disability if he is capable of increased utilization of such work skills or abilities.

(*b*) *Substantial Gainful Activity Defined.*—Substantial gainful activity refers to work activity that is both substantial and gainful. Substantial work activity involves the performance of significant physical or mental duties, or a combination of both, productive in nature. Gainful work activity is activity for remuneration or profit (or intended for profit, whether or not a profit is realized) to the individual performing it or to the persons, if any, for whom it is performed, or of a nature generally performed for remuneration [illegible] In order for work activity to be substantial, it is not necessary that [illegible]ed on a full-time basis; work activity performed on a part-tim[illegible] also be substantial. It is immaterial that the work activity of a[illegible]ual may be less, or less responsible, or less gainful, than that in which [illegible]as [illegible]gaged before the onset of his impairment.

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[1] Code of Federal Regulations, title 20, pt. 404, subpart P.

(*c*) *Nature of the Work.*—The performance of duties involving skill, experience or responsibility, or contributing substantially to the operation of an enterprise is evidence tending to show that an individual has ability to engage in substantial gainful activity.

(*d*) *Adequacy of Performance.*—The adequacy of an individual's performance of assigned work is also evidence as to whether or not he has ability to engage in substantial gainful activity. The satisfactory performance of assignments may demonstrate ability to engage in substantial gainful activity, while an individual's failure, because of his impairment, to perform ordinary or simple tasks satisfactorily without supervision or assistance beyond that usually given other individuals performing similar work, may constitute evidence of an inability to engage in substantial gainful activity. "Made work," that is, work involving the performance of minimal or trifling duties which make little or no demand on the individual and are of little or no utility to his employer, or to the operation of a business, if self-employed, does not demonstrate ability to engage in substantial gainful activity.

(*e*) *Special Employment Conditions.*—Work performed under special conditions of employment which take account of the employee's impairment (for example, work in a sheltered workshop or in a hospital by a patient) may, nonetheless, provide evidence of skills and abilities that demonstrate an ability to engage in a substantial gainful activity, whether or not such work in itself constitutes substantial gainful activity (*see* § 404.1534 (*b*) and (*c*)).

(*f*) *Activities in Carrying on a Trade or Business.*—Supervisory, managerial, advisory or other significant personal services rendered by a self-employed individual demonstrate an ability to engage in substantial gainful activity.

(*g*) *Work Activity of Blind Applicants.*—The work of an applicant for disability insurance benefits who has not attained age 55 and has applied for benefits based on statutory blindness is evaluated to determine whether he is able to engage in substantial gainful activity. If he has attained age 55, his work is evaluated also to determine whether he is utilizing skills or abilities comparable to those of any gainful activity in which he had previously engaged with some regularity over a substantial period of time. If his work establishes that he is able to engage in substantial gainful activity, and if (he has attained age 55) also that he is utilizing such skills or abilities or can utilize them therein, he is not under a disability for the purposes of disability insurance benefits (*see* 404.1501(*a*)(1)(ii). (Paragraph (*a*) amended and paragraph (*f*) added 1–3–68.) (Section amended 8–20–68.)

404.1533 Time spent in work

If the time that an individual spends in work activities is comparable to the time customarily spent by individuals without impairment in similar work activities as a regular means of livelihood, his ability to work for such periods constitutes evidence tending to show an ability to engage in substantial gainful activity. Moreover, where an individual, because of his impairment, is unable to spend as much time in work activities as is customarily spent by individuals without impairment in similar work, but such individual is able to perform significant duties on a part-time basis, his ability to work on a part-time basis also tends to show an ability to engage in substantial gainful activity. (Amended 8–20–68.)

404.1534 Evaluation of earnings from work

(*a*) *General.*—Where an individual who claims to be disabled engages in work activities, the amount of his earnings from such activities may establish that the individual has the ability to engage in substantial gainful activity. Generally, activities which result in substantial earnings would establish ability to engage in substantial gainful activity; however, the fact that an individual's activities result in earnings which are not substantial does not establish the individual's inability to engage in substantial gainful activity. Where an individual is forced to discontinue his work activities after a short time because his impairment precludes continuing such activities, his earnings would not demonstrate ability to engage in substantial gainful activity. Also a mentally handicapped individual who performs simple tasks subject to close and continuous supervision would not have demonstrated ability to engage in substantial gainful activity solely on the basis of the rate of his remuneration for such activity. Extraordinary expenses incurred by an individual in connection with his employment and because of his impairment (e.g., the nature of the impairment requires special transportation) shall be deducted, to the extent that such expenses exceed what would be his work-related expenses if he were not impaired in computing the value of his earnings. Expenses for medication or equipment which the individual requires whether or not he works would not, of course, be work-related. Earnings received by an employee which are not attributable to his work activity are not considered in determining his ability to engage in substantial gainful activity. Thus, where an individual engages in work activity as an employee under special conditions (*see* § 404.1532(*e*)), only earnings attributable to the individual's productivity, as distinguished from a subsidy related to other factors (e.g., his financial needs), are considered in determining his ability to perform substantial gainful activity. The fact, however, that a sheltered workshop or comparable facility may operate at a deficit and receive some charitable contributions or governmental aid would not necessarily establish that a particular employee of the workshop is not earning the amounts paid to him.

(*b*) *Earnings at a Monthly Rate in Excess of $140.*—An individual's earnings from work activities averaging in excess of $140 a month shall be deemed to demonstrate his ability to engage in substantial gainful activity unless there is affirmative evidence that such work activities themselves establish that the individual does not have the ability to engage in substantial gainful activity under the criteria in §§ 404.1532 and 404.1533 and paragraph (*a*) of this section.

(*c*) *Earnings at a Rate of $90 to $140 a Month.*—Where an individual's earnings from work activities average between $90 and $140 a month, consideration of the amount of his earnings together with the other circumstances relating to his work activities (*see* §§ 404.1532 and 404.1533), the medical evidence relating to his impairment or impairments, and other factors (*see* § 404.1502) shall determine whether such individual is able to engage in substantial gainful activity. However, in the case of an individual working in a sheltered workshop (such as a workshop especially organized for the blind) or comparable facility, whose activities are limited by his impairment so that his earnings average $140 a month or less, such activities and such earnings ordinarily would not establish the ability to engage in substantial gainful activity.

(*d*) *Earnings at a Monthly Rate of Less Than $90.*—Earnings from work activities as an employee which average less than $90 a month do not show that the individual is able to engage in substantial gainful activity. However, an evaluation of the work performed (*see* § 404.1532) may establish that the individual is able to engage in substantial gainful activity, regardless of the amount of his average monthly earnings.

(*e*) *Factors Considered Where Individual is Self-Employed.*—The earnings or losses of a self-employed individual often reflect factors other than the individual's work activities in carrying on his trade or business. For example, a business may have a small income or may even operate at a loss even though the individual performs sufficient work to constitute substantial gainful activity. Thus, less weight is given to such small income or losses in determining a self-employed individual's ability to engage in substantial gainful activity, and greater weight is given to such factors as the extent of his activities and the supervisory, managerial, or advisory services rendered by him (*see* § 404.1532(*f*)). Paragraphs (*b*), (*c*), and (*d*) amended 1-3-68. (Section amended 8-20-68, 1-10-69.)

EARNINGS OF DISABLED-WORKER BENEFICIARIES[2]

(By Paula A. Franklin[3])

Information from the 1-Percent Continous Work History Sample describes some of the major charactertistics of employed disabled-worker beneficiaries. The earner represents a small minority within the beneficiary population as a whole. Younger beneficiaries, men, blacks, the most recently entitled, and those with the highest predisability earnings are most likely to continue working. The dominant pattern of employment appears to be part-time, intermittent work resulting in a low earnings level. Ninety percent of the beneficiary population earn nothing, 5 percent earn less than $600, 3 percent earn between $600 and $1,679, and only about 2 percent earn $1,680 or more a year. The very few beneficiaries able to sustain themselves through long-term, full-time employment are probably in the process of the trial work period and consequent termination of benefits.

At the end of 1970, almost one and a half million workers were receiving disabled-worker benefits under the social security program averaging about $130 a month. Entitlement to disability benefits is based on the existence of a mental or physical impairment that is expected to last for at least 12 months. In addition, the medical condition must be so severe that the disabled person can no longer engage in substantial, gainful activity (SGA).[4] Of the number of disabled workers whose benefits are in current-payment status at any given time, 1–2 percent have their benefits terminated because of medical recovery or earnings above the SGA level. A recent study has described the characteristics and earnings of disabled workers whose benefits were terminated for these reasons.[5] This article, in contrast, provides a descriptive analysis of earnings and other data—such as the number of beneficiaries who work, the amount they earn, and their patterns of employment—for all persons receiving disabled-worker benefits at the beginning of 1971.

The data base, the 1-Percent Continuous Work History Sample,[6] provides the 1970 earnings record and other characteristics of the disabled-worker beneficiaries. The earnings record is compiled from earnings in covered employment as reported to the Social Security Administration. The study population includes only disabled-worker beneficiaries entitled before 1970, i.e., during 1969 and preceding years. Since the study presents earnings data for calendar year 1970, work records for persons entitled in 1970 were excluded because those records might have reflected preaward as well as postaward earnings.

Extent of work after disability

Few disabled workers increase their income through earnings. Only 10 percent, about 127,000 of almost 1.3 million, report any earnings at all. More than 7 of every 10 of those working earn under $1,680. For those with earnings, the annual median is $644; about half earn under $600 a year. Ninety percent of the total beneficiary population earn nothing (table 95).

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[2] From Social Security Bulletin, June 1974 pp. 18–22.

[3] Division of Disability Studies, Office of Research and Statistics. Assistance from the Division of Old-Age, Survivors, and Disability Insurance Statistics was provided by Warren L. Buckler and Robert H. Finch.

[4] For administrative purposes, substantial gainful activity is defined as the ability to earn $140 a month or $1,680 annually. The SGA level was originally established at $100 when the disability insurance program began in 1958. The level has been increased twice by 1966 and 1968 regulations to $125 and $140, respectively, to keep abreast of the rising wage levels.

[5] See Jack Schmulowitz, "Recovery and Benefit Termination: Program Experience of Disabled-Worker Beneficiaries," *Social Security Bulletin*, June 1973, tables 1 and 2.

[6] See the Technical Note at the end of the article.

Characteristics of working beneficiaries

The young beneficiary is more likely to be employed than the older beneficiary. Although the absolute number of employed disabled-worker beneficiaries increases with age because more older pople are disabled, the proportion of beneficiaries with earnings decreases with age. Only about 9 percent of the more than 1 million disabled-worker beneficiaries between ages 45 and 65 work, compared with 19 percent of the 200,000 beneficaries under age 45 (table 96). When the beneficiary reaches age 65, his disabled-worker benefits are converted into retired-worker benefits.

TABLE 95.—*Earnings in 1970 of disabled-worker beneficiaries with entitlement before 1970, by amount of earnings and sex*

Amount of earnings	Total	Men	Women
Total number	1, 294, 600	915, 200	379, 400
Total percent	100. 0	100. 0	100. 0
Without earnings	90. 2	89. 2	92. 7
$1 to $599	4. 8	5. 0	4. 2
$600 to $1,199	2. 0	2. 2	1. 6
$1,200 to $1,679	1. 1	1. 2	. 7
$1,680 to $2,399	. 7	. 9	. 3
$2,400 to 3,599	. 6	. 7	. 4
$3,000 or more	. 6	. 8	. 1
Median earnings	*$644*	*$720*	*$508*
95-percent confidence limits of median	*578–734*	*622–817*	*431–586*

Seven of every 10 social security disabled-worker beneficiaries are men, yet they account for 8 of every 10 persons earning additional income. Thus, not only are women less likely to be receiving disability benefits, but they are also less likely to continue working after entitlement. Fewer than 1 in 3 of those receiving disabled-worker benefits are women; of the beneficiaries with earnings, women number less than 1 in 4.

Women's earnings average less than men's. Although about 2 in 5 of the employed men earn less than $600, 3 in 5 employed women are in this category. More than 20 percent of the men earn above $1,680, compared with less than 10 percent of the women. The median amount of earnings for men is 40 percent higher than that for women, $720 compared with $508. Both men and women follow the pattern noted earlier: a greater proportion of younger beneficiaries participate in the work force, although the absolute number of earners is greater among those over age 45.

Severe disabilities appear to be more prevalent among blacks. Just over 11 percent of the workers insured for disabled-worker benefits in 1970 were black, but they comprised 15 percent of those receiving disabled-worker benefits.[7] A greater proportion of blacks continue with some employment. One in every 8 black beneficiaries has earnings, in contrast to less than 1 in 10 of the whites.

The median income for white women was almost $250 less than that for white men. The employment pattern of black women differs from that of white women. Of all women receiving disabled-worker benefits, 1 in 9 black women increases her income with earnings, in contrast to 1 in 15 white women. Nearly a fourth of women beneficiaries working are black, although they represent only 15 percent of all women with benefits in current-payment status.

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[7] Jack Schmulowitz, *Social Security Benefits and Earnings of Minority Groups in Covered Employment* (Research and Statistics Note No. 5), Office of Research and Statistics, June 1971.

TABLE 96.—*Earnings in 1970 of disabled-worker beneficiaries with entitlement before 1970, by age, sex, and race*

Age in 1970, sex, and race [1]	Number of beneficiaries	Percent with earnings	Percent with earnings over $1,680	Median earnings	95-percent confidence limits of median
Under 35	64, 900	26. 2	2. 6	$745	$537–$1, 048
35 to 44	140, 100	14. 8	2. 1	622	505–856
45 to 54	347, 100	9. 7	1. 7	581	497–738
55 to 64	742, 500	7. 5	2. 0	674	576–792
Men:					
Under 35	51, 500	27. 2	2. 9	800	538–1, 176
35 to 44	106, 400	16. 1	2. 2	675	519–921
45 to 54	241, 800	10. 1	1. 9	639	518–854
55 to 64	515, 500	8. 4	2. 2	756	621–891
Women:					
Under 35	[illegible]	22. 4	1. 3	600	330–1, 041
35 to 44	[illegible]	10. 7	1. 7	482	226–1, 024
45 to 54	10[illegible], 300	8. 6	1. 1	497	359–672
55 to 64	227, 000	5. 3	1. 1	504	394–634
White men	762, 800	10. 3	2. 2	748	640–856
Under 35	39, 700	25. 9	2. 9	762	508–1, 246
35 to 44	85, 600	16. 1	2. 1	716	529–969
45 to 54	201, 300	9. 8	1. 8	687	521–934
55 to 64	436, 200	7. 9	2. 3	787	638–935
White women	319, 300	6. 6	1. 2	505	410–601
Under 35	11, 400	21. 9	1. 2	643	313–1, 089
35 to 44	28, 200	9. 2	1. 9	490	196–1, 256
45 to 54	89, 800	7. 9	1. 0	449	292–615
55 to 65	189, 900	4. 6	1. 1	523	397–722
Black men	137, 400	13. 1	2. 1	616	496–855
Under 35	10, 200	29. 4	1. 7	825	424–1, 341
35 to 44	17, 900	14. 5	2. 7	600	332–1, 368
45 to 54	37, 000	11. 9	2. 1	513	307–909
55 to 64	72, 300	11. 1	1. 8	635	472–966
Black women	56, 900	10. 9	1. 2	524	366–753
Under 35	1, 500	20. 0	0	(2)	(2)
35 to 44	5, 000	18. 0	2. 0	(2)	(2)
45 to 54	14, 800	12. 8	1. 6	729	384–1, 126
55 to 64	35, 600	8. 7	1. 0	472	252–814

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[1] Excludes an estimated 15,000 or 1.6 percent of the total male disabled population and an estimated 3,200 or 0.8 percent of the total female population that are of other races or of unknown origin.
[2] Not computed on basis of fewer than 1,000 persons with earnings.

Earnings after entitlement

When do the few working beneficiaries reenter the labor market in relation to the developmental cycle of their disability? Although the time of the disability onset is not specified in the study data, earnings information is available by year of beneficiary entitlement. The date of entitlement always begins after a required waiting period—currently 5 months but before the 1972 amendments, 6 months. Entitlement can, however, occur at a later time than the beginning stages of the disease or infirmity since the medical condition may not initially be sufficiently severe for the disabled worker to qualify for an award under the definition of disability used in the social security program.

Data on annual earnings indicate that more people work and earn income the first year after entitlement than in subsequent years. About 20 percent of the almost quarter-million persons initially entitled to benefits in 1969 had earnings in 1970 (table 97). For persons entitled before 1969 the number and proportion of those with earnings in 1970 diminishes rapidly. Ten percent have earnings during the second year after entitlement; after more than 3 years the proportion levels off at about 7 percent. Further research is needed to analyze earnings records of beneficiaries for a series of years in order to determine whether this pattern of labor-market participation is specific only to 1970 or if it is general.

The amounts earned by beneficiaries who worked in 1970 were generally small and differed little with entitlement year or the length of time benefits were received. Table 98 shows the median earnings by number of quarters worked for disabled-worker beneficiaries in 1970.

TABLE 97.—*Earnings in 1970 of disabled-worker beneficiaries with entitlement before 1970, by year of entitlement*

Years of entitlement and number of years after entitlement	Number of beneficiaries	Percent with earnings	Median earnings	95 percent confidence limits of median
1969 (1 year)	248, 600	19. 9	$613	$541–$767
1968 (2 years)	217, 500	10. 3	645	519–889
1967 (3 years)	159, 700	8. 3	609	477–841
1966 (4 years)	127, 000	7. 3	653	456–1, 010
1965 (5 years)	115, 200	7. 1	553	404–860
Before 1965 (5 years or more)	426, 600	5. 6	739	594–886

TABLE 98.—*Earnings in 1970 of disabled-worker beneficiaries with entitlement before 1970, by earnings status and quarters of coverage*

Earnings status and quarters of coverage	Total	Median earnings	95-percent confidence limits of median
Total number	1, 294, 600		
Total percent	100. 0		
Without earnings	90. 0		
With earnings:			
Less than one quarter [1]	1. 0	$29	$23–$34
1 quarter	3. 0	394	356–431
2 quarters	2. 0	776	631–922
3 quarters	1. 0	1, 283	1, 050–1, 528
4 quarters	3. 0	1, 455	1, 301–1, 609

[1] Represents those who earned less than $50 during the entire year and therefore not credited for one quarter of social security coverage (a quarter of coverage is a calendar quarter in which a person earns $50 or more in wages).

Examination of these data indicates that the majority of those with jobs are employed two quarters or less, which produced low median earnings figures and suggests intermittent, part-time work. Relatively few were able to participate in continuous employment. Only 3 percent, around 36,000 persons, worked all four quarters of 1970. Although they earned limited amounts (a median of $1,455), other studies suggest that many of the recovered persons whose benefits are terminated come from this group. With the data available for this study the higher earnings beneficiaries could not be traced beyond 1970 to determine the number who recovered and were terminated.

Earnings before disability entitlement

Until this point, earnings of persons after their entitlement to disabled-worker benefits has been the central focus. As has been shown, the data indicate that a small proportion of the disabled-worker beneficiary population continues to work after entitlement, earning small amounts. The question arises, however, as to the economic position of disabled-worker beneficiaries before the onset of their long-term illness. Is there a relationship between previous earnings and earnings after disability? To answer this, the earnings data reported in social security records 3 years before entitlement are examined in relation to 1970 earnings.

At least $1,680 was earned by 3 of every 5 beneficiaries during the third year before entitlement, but only 1 in 14 had made more than $5,400 (table 99). The median earnings of the total disabled-worker population for the third year before entitlement—$2,390—was lower than the $3,149 median of all workers in covered employment in 1963.[8] During 1963 about 25 percent of the labor force earned more than $5,400;[9] only 7 percent of the disabled-worker beneficiaries did.

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[8] Of the 1.3 million disabled-worker beneficiaries receiving benefits in January 1971, about half had become entitled from the program's beginning in 1958 through 1966. The year 1963 was selected as the base year to compare median earnings of all workers with beneficiary earnings 3 years before entitlement.

[9] Bureau of the Census, *Consumer Income*, table 32, "Type of Income in 1963 for Persons 14 Years Old and Over," Series P–60, No. 43, September 1964.

Table 99.—*Earnings in 1970 of disabled-worker beneficiaries with entitlement before 1970, by earnings in 3d year before entitlement*

Earnings in third year before entitlement	Number of beneficiaries	Percent with earnings, 1970	Median earnings, 1970	95-percent confidence limits of median
Total	1, 294, 690	9. 8	$644	$578–734
Without earnings	200, 900	6. 2	654	497–915
$1 to 599	108, 000	12. 5	488	353–549
$600 to $1,679	210, 400	10. 9	597	495–776
$1,680 to $3,599	333, 700	8. 9	628	526–838
$3,600 to $5,399	350, 600	8. 0	909	742–1, 077
$5,400 or more	91, 000	22. 1	626	508–899

Findings from previous studies [10] indicate that disabled beneficiaries are disproportionately represented in semiskilled and unskilled occupations; the proportion with white-collar jobs was half that of the work force as a whole.

Fifteen percent of the disabled-worker beneficiaries at the end of 1970 had no recorded earnings 3 years before entitlement. A worker may acquire fully insured status and thus qualify for disability benefits by working in covered employment 20 of the 40 quarters before the onset of disability. The data in this report, however, are not able to explain why almost 1 beneficiary in 6 had no earnings in the third year before entitlement.

Labor-force participation 3 years before entitlement generally does not predict work after disability. Some of the beneficiary groups with no earnings 3 years before entitlement had reported earnings in 1970. One in 5 of the small group of beneficiaries who had previously earned more than $5,400 worked after entitlement. Only 1 in 10 of those who earned less than that amount before their disability were employed after entitlement.

It is probable that persons who earned more than $5,400 were better educated, more skilled, and may have had greater employment opportunities available to them. Disabled-worker beneficiaries who participate in State rehabilitation programs [11] tend to have higher predisability earnings and are younger than the average social security disabled-worker beneficiary.

On the basis of these data, the relationship between predisability and postdisability earnings is inconclusive. Postdisability earnings did not vary consistently with different levels of predisability earnings. Therefore, the level of earnings before long-term illness does not determine the amount of earnings as a disabled person. The earnings experience of all beneficiaries after disablement, however, is remarkably consistent. Regardless of earnings 3 years before entitlement, median earnings for beneficiaries working a year or more after entitlement did not vary greatly. Earnings in 1970 showed an average loss of almost 75 percent from the predisability levels for those few who continued to work. Reports from the 1966 social security survey of the disabled note that low median earnings gained from part-time or intermittent work is the general pattern of all the severely disabled within the United States.

Types of income

Do some kinds of work activity produce greater returns for earning beneficiaries? Are the proceeds from self-employment, for example, greater than wages? What is the most remunerative type of work? What is the dominant mode of employment?

When beneficiaries work, they are mainly wage earners, as are most workers. More than 85 percent of the 1970 beneficiaries with earnings worked for wages only, compared with 93 percent of all covered workers. The proportion of wage earners among women was even greater—more than 95 percent. Types of work activity have traditionally been more diversified for men, however. More than 15 percent farmed, were self-employed, or combined wages with farming or self-employment.

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[10] For further discussion, see Lawrence D. Haber, "The Disabled Beneficiary—A Comparison of Factors Related to Benefit Entitlement," *Social Security Survey of the Disabled, 1966* (Report No. 7), June 1969.

[11] Ralph Treitel, "Recovery of Disabled After Trust Fund Financing of Rehabilitation," *Social Security Bulletin*, February 1973.

Outstanding are the economic returns from self-employment and from the combination of wages and self-employment (table 100). For the working beneficiary the median earnings for these two categories are 3–4 times that of wages alone. Previous studies[12] indicate that disabled men are more likely to shift to or continue in self-employment and farming after disablement than to continue in or begin other types of work. Farming and self-employment offer more flexibility in time and working conditions and greater adaptability to the special needs of the handicapped.

TABLE 100.—*Earnings in 1970 of disabled-worker beneficiaries with entitlement before 1970, by type of earnings*

Type of earnings	Working beneficiaries		Median earnings	95-percent confidence limits of median
	Number	Percentage distribution		
Total	126. 700	100. 0		
Nonfarm	109, 800	86. 7	$560	$519– $605
All self-employment	10. 800	8. 5	1, 451	1, 136–1, 656
Farm	3, 700	2. 9	675	424–1, 006
Nonfarm and all self-employment	1, 200	. 9	2, 160	1, 260–4, 680
Nonfarm and farm	1, 200	. 9	750	314–1, 488
Men	98, 900	100. 0		
Nonfarm	83, 100	84. 0	585	537– 683
All self-employment	10, 000	10. 1	1, 468	1, 141–1, 664
Farm	3, 600	3. 6	700	434–1, 026
Nonfarm and all self-employment	1, 000	1. 0	2, 400	[1] 1, 541–5, 400
Nonfarm and farm	1, 200	1. 2	750	314–1, 488
Women	27, 800	100. 0		
Nonfarm	26, 700	96. 0	491	415– 568
All self-employment	800	2. 9	(2)	(2)
Farm	100	. 3	(2)	(2)
Nonfarm and all self-employment	200	. 7	(2)	(2)

[1] Represents more than $5,400.
[2] Not computed on base of fewer than 1,000 persons with earnings.

SGA level and future research

The 1972 and 1973 social security amendments raised the earnings test for retired workers to $175 a month effective January 1973 and to $200 effective January 1974. Currently, consideration is being given to the adequacy of the "substantial gainful activity" level now set at $140 a month for disabled-worker beneficiaries. Projections from this study suggest that increasing the level to $200 a month would have a relatively small effect on the number of disabled-worker beneficiaries in current-payment status. At most, about 10,000 persons would continue receiving benefits if they could earn above $1,680 but below $2,400 a year. Less than 1 percent of the total disabled-worker population earn in that range, and just over 1 percent earn above the $2,400 level.

Although some distinguishing characteristics of the earning disabled-worker beneficiary emerge from this study, further research is needed to trace other patterns. Exploration might furnish more information on the relationship between specific diseases and work attempts, the major occupations providing part- and full-time work, the significant factors encouraging labor-force participation, the contribution of beneficiary earnings to adequacy of income, the relationship between amount of earnings during the trial work period and terminations, and the effect of work adjustments after disability on occupational mobility. Data from future studies may be able to describe more fully the severely disabled person who is still working.

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[12] See Lawrence D. Haber, *op. cit.*, page 9, and Constantine Safilios Rothschild, *The Sociology and Social Psychology of Disability and Rehabilitation*, Random House, 1970, page 197.

9. Supplemental Security Income—Selected Information

A. Payments and Beneficiaries

Table 101.—*Supplemental security income for the disabled: Number of persons receiving federally assisted payments, and total amount of benefits—January–April 1974*

		Benefits (in thousands)		
	All person [1]	Total	Federal SSI [2]	State supplementation [3]
January	1, 278, 133	177, 673	128, 302	49, 371
February	1, 280, 893	192, 585	148, 442	44, 143
March	1, 314, 003	201, 397	152, 725	48, 672
April	1, 307, 611	188, 193	142, 750	45, 443
May	1, 337, 881	201, 690	153, 903	47, 786

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[1] Distribution of persons receiving benefits on the basis of Federal SSI payments and federally administered State supplementation not provided for February or March data.

[2] Includes retroactive adjustment reflecting the benefit standards increase for January 1974.

[3] Does not include payments for State supplementation under State-administered programs.

Table 102.—*Supplemental security income for the aged, blind, and disabled. Number of persons receiving payments, by State, January 1974*

State	Total	Aged	Blind	Disabled
Total	3, 215, 632	1, 865, 109	72, 390	1, 278, 133
Alabama	125, 090	101, 953	1, 770	21, 367
Alaska	2, 780	1, 167	78	1, 535
Arizona	22, 490	11, 870	361	10, 259
Arkansas [1]	74, 103	57, 213	1, 649	15, 241
California [1]	518, 977	286, 138	13, 298	219, 541
Colorado	37, 314	22, 986	273	14, 055
Connecticut	15, 259	6, 121	158	8, 980
Delaware [1]	5, 617	3, 034	328	2, 255
District of Columbia [1]	14, 755	4, 706	188	9, 861
Florida [1]	101, 770	71, 788	2, 198	27, 784
Georgia [1]	132, 454	87, 568	3, 117	41, 769
Hawaii [1]	6, 793	3, 584	96	3, 113
Idaho	6, 213	2, 972	88	3, 153
Illinois [1]	127, 762	35, 919	1, 735	90, 109
Indiana [1]	28, 026	15, 320	1, 156	11, 550
Iowa [1]	16, 927	12, 163	967	3, 797
Kansas [1]	16, 991	9, 616	360	7, 015
Kentucky	74, 740	52, 910	1, 934	19, 896
Louisiana [1]	134, 212	104, 068	2, 089	28, 055
Maine [1]	20, 260	11, 885	276	8, 099
Maryland [1]	38, 438	12, 428	445	25, 565
Massachusetts [1]	89, 942	56, 877	2, 886	30, 179
Michigan [1]	93, 536	38, 704	1, 701	53, 131
Minnesota [1]	31, 607	14, 594	820	16, 193
Mississippi	110, 933	80, 804	1, 839	28, 290
Missouri	97, 002	71, 632	2, 578	22, 792
Montana [1]	6, 303	2, 862	171	3, 270
Nebraska	13, 668	6, 751	259	6, 658
Nevada [1]	3, 299	3, 077	107	115
New Hampshire	3, 958	2, 503	143	1, 312
New Jersey [1]	45, 182	22, 431	812	21, 939
New Mexico	19, 197	3, 165	396	10, 636
New York	287, 369	107, 095	4, 086	176, 188
North Carolina	88, 761	47, 180	3, 829	37, 752
North Dakota	5, 620	3, 553	42	2, 025
Ohio [1]	97, 297	43, 315	2, 352	51, 630
Oklahoma	75, 840	52, 220	1, 024	22, 596
Oregon	18, 032	7, 267	498	10, 267
Pennsylvania [1]	97, 194	44, 961	5, 721	46, 512
Rhode Island [1]	10, 212	4, 086	165	5, 961
South Carolina [1]	42, 222	24, 437	2, 026	15, 759
South Dakota [1]	5, 867	3, 733	111	2, 023
Tennessee [1]	89, 927	55, 401	1, 583	32, 943
Texas	208, 964	173, 745	3, 498	31, 721
Utah [1]	7, 893	2, 674	167	5, 052
Vermont	5, 926	3, 243	63	2, 620
Virginia	32, 683	17, 744	1, 181	13, 758
Washington [1]	47, 078	17, 028	431	29, 619
West Virginia	25, 953	13, 252	519	12, 182
Wisconsin [1]	30, 852	19, [illegible]	792	10, 893
Wyoming [1]	2, 344	1, 199	27	1, 118

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[1] Represents persons with Federal SSI payments and/or federally administered State supplementation; the remaining States have State-administered Supplementation, but since such data are not available, the figures represent only the Federal SSI payments.

TABLE 103.—*Supplemental security income for the aged, blind, and disabled: Number of persons receiving federally administered payments by State, April 1974*

State	Total	Aged	Blind	Disabled
Total [1]	3, 334, 493	1, 953, 693	73, 189	1, 307, 611
Alabama [2]	125, 968	101, 049	1, 971	22, 948
Alaska [2]	2, 594	1, 082	80	1, 432
Arizona [2]	23, 299	12, 359	426	10, 514
Arkansas	74, 087	56, 688	1, 634	15, 765
California	524, 734	286, 624	13, 145	224, 965
Colorado [2]	36, 128	22, 117	317	13, 694
Connecticut [2]	17, 776	7, 185	207	10, 384
Delaware	5, 375	2, 924	305	2, 146
District of Columbia	14, 461	4, 641	187	9, 633
Florida	107, 239	74, 887	2, 219	30, 133
Georgia	133, 967	88, 153	3, 091	42, 723
Hawaii	6, 811	3, 758	101	2, 952
Idaho [2]	6, 670	3, 270	95	3, 305
Illinois	127, 071	38, 977	1, 651	86, 443
Indiana	30, 686	17, 369	1, 156	12, 161
Iowa	19, 626	14, 040	940	4, 646
Kansas	18, 217	10, 452	353	7, 412
Kentucky [2]	77, 387	53, 811	1, 994	21, 582
Louisiana	131, 677	100, 834	2, 060	28, 783
Maine	19, 973	11, 637	273	8, 063
Maryland	40, 396	14, 036	442	25, 918
Massachusetts	97, 784	63, 012	2, 854	31, 918
Michigan	95, 326	41, 051	1, 645	52, 630
Minnesota	32, 195	15, 750	776	15, 669
Mississippi [2]	112, 944	81, 413	2, 010	29, 521
Missouri [2]	97, 439	70, 495	2, 788	24, 156
Montana	6, 612	3, 080	157	3, 375
Nebraska [2]	13, 754	7, 446	230	6, 078
Nevada	3, 440	2, 994	107	339
New Hampshire [2]	4, 230	2, 717	183	1, 330
New Jersey	49, 601	25, 598	864	23, 139
New Mexico [2]	20, 040	9, 104	397	10, 539
New York	296, 989	122, 305	3, 951	170, 733
North Carolina [2]	101, 287	55, 876	4, 128	41, 283
North Dakota [2]	6, 184	3, 985	52	2, 147
Ohio	100, 648	45, 558	2, 308	52, 782
Oklahoma [2]	77, 002	52, 464	1, 058	23, 480
Oregon [2]	19, 774	8, 227	619	10, 928
Pennsylvania	101, 189	48, 638	5, 629	46, 922
Rhode Island	11, 269	4, 953	158	6, 158
South Carolina	48, 293	29, 456	1, 955	16, 882
South Dakota	6, 359	4, 200	94	2, 065
Tennessee	97, 268	61, 016	1, 599	34, 653
Texas [2]	216, 548	177, 894	3, 610	35, 044
Utah	7, 853	2, 928	152	4, 773
Vermont [2]	6, 290	3, 439	74	2, 777
Virginia [2]	40, 453	23, 745	1, 302	15, 406
Washington	48, 134	17, 847	462	29, 825
West Virginia [2]	28, 678	15, 341	544	12, 793
Wisconsin	40, 057	25, 871	802	13, 384
Wyoming	2, 246	1, 254	28	964
Unknown	465	143	6	316

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[1] Includes persons with Federal SSI payments and/or federally administered State supplementation, unless otherwise indicated.

[2] Data for Federal SSI payments only. State has State-administered supplementation but data for such payments are not available.

TABLE 104.—*Supplemental security income for the aged, blind, and disabled: Combined Federal SSI payments and federally administered State supplementary payments, by State, April 1974*

[In thousands of dollars]

State	Aged	Blind	Disabled
Total	193, 691	10, 237	188, 193
Alabama	7, 823	223	2, 604
Alaska	87	10	177
Arizona	1, 058	50	1, 241
Arkansas	4, 846	190	1, 571
California	39, 934	2, 654	43, 641
Colorado	1, 583	32	1, 536
Connecticut	522	22	1, 173
Delaware	249	36	256
District of Columbia	439	23	1, 211
Florida	8, 252	268	3, 524
Georgia	7, 964	361	4, 510
Hawaii	473	17	502
Idaho	240	10	333
Illinois	3, 186	211	10, 618
Indiana	1, 307	127	1, 161
Iowa	1, 123	123	506
Kansas	832	40	769
Kentucky	4, 957	278	2, 697
Louisiana	9, 458	256	3, 277
Maine	925	33	991
Maryland	1, 304	57	3, 348
Massachusetts	9, 404	542	6, 556
Michigan	4, 089	228	7, 604
Minnesota	1, 240	95	1, 752
Mississippi	6, 358	243	3, 211
Missouri	5, 320	257	2, 750
Montana	230	17	406
Nebraska	505	25	623
Nevada	294	17	42
New Hampshire	166	17	137
New Jersey	2, 710	113	3, 273
New Mexico	833	45	1, 214
New York	16, 598	679	31, 882
North Carolina	4, 401	467	4, 883
North Dakota	304	6	235
Ohio	3, 745	265	6, 422
Oklahoma	4, 259	128	2, 589
Oregon	600	65	1, 249
Pennsylvania	4, 625	682	6, 114
Rhode Island	401	20	773
South Carolina	2, 723	228	1, 977
South Dakota	353	12	229
Tennessee	5, 455	201	4, 110
Texas	13, 655	420	3, 737
Utah	256	18	545
Vermont	240	8	313
Virginia	2, 027	155	1, 901
Washington	1, 715	69	4, 397
West Virginia	1, 418	70	1, 632
Wisconsin	3, 096	117	1, 842
Wyoming	92	4	104
Unknown	16	1	48

TABLE 105.—*Supplemental security income for the aged, blind, and disabled: Number of persons receiving payments and total and average amount, by type of payment, January 1974*

Type of payment	Total	Aged	Blind	Disabled
	Number of persons			
All persons	3, 215, 632	1, 865, 109	72, 390	1, 278, 133
With Federal SSI payments [1]	2, 955, 959	1, 690, 496	55, 680	1, 209, 783
Federal SSI only	1, 735, 413	1, 094, 791	35, 064	605, 558
Federal SSI and State supplementation	1, 220, 546	595, 705	20, 616	604, 225
With State supplementation only [2]	259, 673	174, 613	16, 710	68, 350
	Total amount (in thousands)			
Total	$365, 149	$178, 479	$8, 996	$177, 673
Federal SSI payments [3]	260, 159	126, 009	5, 848	128, 302
State supplementation [4]	104, 989	52, 471	3, 148	49, 371
	Average monthly amount			
Federal SSI payments [5]	$88. 01	$74. 54	$105. 04	$106. 05
State supplementation [6]	70. 93	68. 12	84. 34	73. 41

[1] Persons receiving Federal SSI payments only or both Federal SSI payments and State supplementation.

[2] Persons receiving federally administered State supplementation only.

[3] All Federal SSI payments, whether or not in combination with State supplementation.

[4] All federally administered State supplementation, whether or not in combination with Federal SSI payments.

[5] Average Federal SSI payment for all persons with such payments.

[6] Average amount of federally administered State supplementation for all persons with such payments.

TABLE 106.—*Amount by which average combined Federal and State payments January 1974, in States with federally administered State supplementation, exceeds average State assistance payments, October 1973*

Less than $10	$10 to $19.99	$20 to $29.99	$30 or more
	Aged [1]		
Arkansas Delaware District of Columbia Illinois Louisiana Maine Minnesota Montana Wyoming	Florida Hawaii Indiana Kansas Massachusetts Nevada Ohio Rhode Island South Dakota Washington	Georgia Maryland Michigan New Jersey Pennsylvania South Carolina Tennessee Utah	California New York Wisconsin
	Blind [1]		
Delaware Illinois Iowa Maine Massachusetts Pennsylvania Rhode Island Utah	Arkansas Florida Hawaii Indiana Maryland Michigan Minnesota New Jersey Ohio South Carolina South Dakota Washington	Georgia Kansas Louisiana	Nevada New York Tennessee Wisconsin

See footnote at end of table.

TABLE 106.—*Amount by which average combined Federal and State payment, January 1974, in States with federally administered State supplementation exceeds average State assistance payments, October 1973*—Continued

Less than $10	$10 to $19.99	$20 to $29.99	$30 or more
Disabled [1]			
Delaware	Arkansas	Georgia	California
District of Columbia	Florida	Hawaii	Louisiana
Illinois	Massachusetts	Indiana	New York
Maine	Minnesota	Kansas	Pennsylvania
Michigan	Montana	Maryland	South Carolina
	Rhode Island	New Jersey	Tennessee
	Utah	Ohio	Wisconsin
	Washington	South Dakota	
	Wyoming		

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[1] Iowa was omitted from the aged and disabled lists due to an error in computing payments. Nevada was omitted from the disabled because the State did not previously have an APTD program. For Wyoming, an AB average for October was not calculated due to the small caseload.

Staff question: ***How many allowances and denials of SSI have been made to date? How many requests for reconsideration have been made? How many disposed of?***

Through June 6, 1974, the State DDU's had completed action on 476,538 SSI–DI claims. Of these, 278,337 were allowances and 198,201 denials. This includes rollback cases.

Through May 29, 1974, 16,393 initially denied SSI disability applicants had requested reconsideration. No reconsideration determinations have as yet been issued.

TABLE 107.—*SSI State agency workload data—week ending June 5, 1974*

Regional offices and States	Total initial SSI claims (blind and disabled) received—		Initial determinations completed to date [1]					
			Allowances		Denials			
	This week	To date	Number	Percent	Number	Percent	Total	Pending
Boston	977	26, 486	10, 690	58. 4	7, 600	41. 6	18, 290	8, 105
Connecticut	123	4, 686	1, 860	59. 7	1, 254	40. 3	3, 114	1, 572
Maine	107	2, 747	1, 357	58. 0	984	42. 0	2, 341	380
Massachusetts	617	13, 373	4, 644	54. 1	3, 935	45. 9	8, 579	4, 750
New Hampshire	34	1, 041	544	67. 1	267	32. 9	811	237
Rhode Island	53	3, 280	1, 614	67. 4	782	32. 6	2, 396	864
Vermont	43	1, 359	671	64. 0	378	36. 0	1, 049	302
New York	3, 383	98, 653	31, 457	54. 9	25, 818	45. 1	57, 275	40, 589
New Jersey	564	17, 682	7, 308	67. 0	3, 597	33. 0	10, 905	6, 451
New York	2, 819	80, 971	24, 149	52. 1	22, 221	47. 9	46, 370	34, 138
Philadelphia	2, 762	73, 922	27, 224	54. 4	22, 829	45. 6	50, 053	22, 927
Delaware	45	1, 071	471	58. 6	333	41. 4	804	231
District of Columbia	54	2, 506	1, 055	71. 2	426	28. 8	1, 481	533
Maryland	1, 028	14, 127	4, 336	49. 3	4, 456	50. 7	8, 792	5, 233
Pennsylvania	940	34, 812	14, 970	61. 4	9, 413	38. 6	24, 383	10, 446
Virginia	478	14, 093	4, 445	44. 3	5, 598	55. 7	10, 043	3, 820
West Virginia	217	7, 313	1, 947	42. 8	2, 603	57. 2	4, 550	2, 664

Footnotes at end of table.

TABLE 07.—*SSI State agency workload data—week ending June 5, 1974*—Continued

Regional offices and States	Total initial SSI claims (blind and disabled) received—		Initial determinations completed to date [1]					
			Allowances		Denials			
	This week	To date	Number	Percent	Number	Percent	Total	Pending
Atlanta	4, 630	151, 996	65, 934	59. 3	45, 324	40. 7	111, 258	36, 832
Alabama	628	19, 263	7, 112	49. 3	7, 316	50. 7	14, 428	4, 321
Florida	1, 020	27, 007	16, 375	75. 4	5, 337	24. 6	21, 712	4, 959
Georgia	664	22, 241	9, 022	54. 4	7, 553	45. 6	16, 575	5, 609
Kentucky	558	14, 338	5, 667	60. 9	3, 634	39. 1	9, 301	4, 862
Mississippi	452	17, 502	6, 285	43. 5	8, 178	56. 5	14, 463	3, 043
North Carolina	521	21, 857	9, 469	63. 7	5, 390	36. 3	14, 859	5, 651
South Carolina	330	11, 962	5, 121	55. 2	4, 154	44. 8	9, 275	2, 514
Tennessee	457	17, 826	6, 883	64. 7	3, 762	35. 3	10, 645	5, 873
Chicago	2, 352	78, 149	37, 179	65. 8	19, 356	34. 2	56, 535	23, 431
Illinois	298	18, 545	6, 223	57. 3	4, 631	42. 7	10, 854	7, 655
Indiana	230	6, 863	3, 456	69. 3	1, 531	30. 7	4, 987	1, 785
Michigan	700	17, 777	8, 932	63. 9	5, 037	36. 1	13, 969	3, 862
Minnesota	108	4, 963	3, 169	78. 6	863	21. 4	4, 032	1, 420
Ohio	755	20, 722	9, 986	64. 8	5, 423	35. 2	15, 409	6, 839
Wisconsin	261	9, 279	5, 413	74. 3	1, 871	25. 7	7, 284	1, 870
Dallas	2, 241	87, 460	37, 385	56. 9	28, 323	43. 1	65, 708	18, 893
Arkansas	316	11, 555	4, 064	45. 4	4, 892	54. 6	8, 956	1, 924
Louisiana	532	22, 529	11, 344	59. 4	7, 752	40. 6	19, 096	3, 482
New Mexico	138	4, 388	1, 254	46. 5	1, 441	53. 5	2, 695	1, 606
Oklahoma	185	11, 179	5, 228	65. 5	2, 757	34. 5	7, 985	3, 149
Texas	1, 070	37, 809	15, 495	57. 4	11, 481	42. 6	26, 976	8, 732
Kansas City	553	26, 339	12, 846	61. 1	8, 174	38. 9	21, 020	5, 155
Iowa	129	4, 599	2, 572	68. 5	1, 185	31. 5	3, 757	840
Kansas	116	4, 681	2, 019	57. 8	1, 472	42 2	3, 491	1, 211
Missouri	248	14, 559	7, 174	60. 9	4, 614	39. 1	11, 788	2, 611
Nebraska	60	2, 500	1, 081	54. 5	903	45. 5	1, 984	493
Denver	396	13, 039	4, 610	52. 9	4, 106	47. 1	8, 716	3, 909
Colorado	148	5, 109	1, 584	47. 3	1, 765	52. 7	3, 349	1, 635
Montana	103	2, 252	837	55. 3	676	44. 7	1, 513	694
North Dakota	34	1, 152	565	59. 7	382	40. 3	947	190
South Dakota	44	1, 074	479	59. 1	332	40. 9	811	267
Utah	45	2, 815	975	60. 7	632	39. 3	1, 607	995
Wyoming	22	637	170	34. 8	319	65. 2	489	128
San Francisco	2, 133	102, 602	42, 617	58. 7	29, 937	41. 3	72, 554	25, 883
Arizona	158	4, 323	1, 619	52. 7	1, 452	47. 3	3, 071	1, 248
California	1, 897	95, 200	39, 560	58. 8	27, 689	41. 2	67, 249	23, 884
Hawaii	33	1, 544	725	65. 7	378	34. 3	1, 103	354
Nevada	45	1, 535	713	63. 0	418	37. 0	1, 131	397
Seattle	471	21, 175	8, 395	55. 5	6, 734	44. 5	15, 129	5, 693
Alaska	23	1, 013	138	29. 7	327	70. 3	465	349
Idaho	66	1, 840	800	56. 7	611	43. 3	1, 411	427
Oregon	154	6, 526	2, 549	58. 6	1, 804	41. 4	4, 353	2, 056
Washington	228	11, 796	4, 908	55. 1	3, 992	44. 9	8, 900	2, 861
National	19, 898	679, 821	278, 337	58. 4	198, 201	41. 6	476, 538	191, 417

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[1] Includes rollback cases.

Source: Management Information Branch, Division of Management Information and Planning, BDI.

B. SOCIAL SECURITY ADMINISTRATION'S EFFORTS TO PROMOTE PUBLIC AWARENESS OF SSI

Staff question: ***Please give a narrative of the effort to inform the public of availability of SSI benefits. Describe in some detail the efforts of the Administration on Aging and how it is coordinated with the social security effort in this area.***

National Organizations

In February 1973, nearly a year before the effective date of the new law, we brought together leaders of more than 100 national organizations to Woodlawn for a briefing on the provisions of H.R. 1, and supplemental security income in particular. As part of the followup, we identified 15 major, representative organizations with close working ties to the aged, blind, and disabled. In August we approached each of the 15 organizations to learn what public information materials they needed to help us in the job of outreach. With these specifics in hand, we produced the materials they needed. We are still actively working with most of these organizations in some degree.

National Media Publicity

To tell the SSI story to national media, we have been in continuing touch with major national news outlets, such as U.S. News and World Report, the Christian Science Monitor, and the national wire services. To date, several key news articles have appeared.

Under Secretary Carlucci briefed Washington-based newsmen in May about the Department's new policies regarding the key questions of State supplementation of SSI payments and Medicaid eligibility. This briefing was followed by press releases from the Department on major SSI policy decisions. DHEW has just begun to release a series of four or five news stories we prepared for the Secretary. We expect such activity to intensify as the time approaches for the new program to start.

District Office Efforts

Social security offices around the country began taking SSI applications in July. Our Office of Public Affairs provided them with a package of draft public information materials to use with local media in announcing the event. These materials included draft news releases, radio spots, and leaflets. Managers did such a good job of placing these materials that by the end of summer, news stories announcing SSI applications had appeared in more than 1,300 newspapers across the country.

Despite these efforts, the initial number of applications amounted to little more than a trickle. To stimulate the flow, we issued a second package of local public information materials in September, and a third in December. Thereafter, SSI information has been included in monthly information packages produced for field offices.

Other Administrative Activity

On a different level, BSSI has been actively in touch with select organizations and with elected and appointed officials in all the states. Our regional public affairs officers have been devoting most of their time to state-by-state public information programs and problems.

Direct Contact with Potential Eligibles

Using our central computer capability, in mid-1973 we indentified 1.6 million potential eligibles for SSI. These were aged, blind and disabled people who were getting social security checks of less than $150 a month. and who were not receiving public assistance. We further pinpointed the likelihood of their eligibility by grouping them according to their zip codes and matching those zip codes against census data which told us which zip codes in the Nation have the highest percentage of the elderly poor.

We distributed those 1.6 million names to social security offices throughout the country, along with a franked self-screening leaflet to be mailed or handed to the elderly person. The leaflet gave him a basic idea of what SSI is, whether he might qualify, and whether he wanted to apply. District offices ran down these leads.

Direct Mail to People Now on Welfare Rolls

In the course of these outreach efforts, we wanted to insure that people already on welfare rolls knew about the changeover to SSI and that they would not need to take the unnecesary anxiety-causing step of applying.

In mid-1973 we furnished all 50 States with a suggested draft message to their aged, blind, and disabled recipients, to be mailed with checks. The message explained the changeover, and assured people their checks would continue automatically without their having to apply.

At the same time, SSA prepared to mail payment decision notices to people converted from State rolls (as well as to successful new applicants). These notices reinforced earlier messages informing them about the new program and told them their specific payment amounts. They received at the same time booklets further explaining the program. Unsuccessful applicants received denial notices telling them in specific terms why they were denied, along with a booklet on their appeal rights.

Electronic Media

All district offices have received a supply of platters containing short SSI radio spot announcements and 5-minute shows. Spanish versions were distributed to district offices where Spanish-surnamed populations warranted.

We have also placed radio spots with the Black Radio Network which has 60 radio stations in the major black markets across the Nation. Dubs of the sound tracks from the Ossie Davis TV spots were also placed with the Network. We have been informed that most of the stations have aired the spots and the reaction has been quite good.

We have produced a 1-minute SSI TV spot and a 30-second SSI TV spot featuring the black actor, Ossie Davis. The National Advertising Council has approved the spot for national public service broadcast on the major TV networks.

We have also produced a Spanish version of these spots featuring Carlos Montalban. Distribution of the Spanish and English versions will be made to the district offices in the next 2 weeks.

Print Media

We have produced and distributed over 30 publications on SSI. These range from simple leaflets printed by the hundreds of thousands for potential eligibles to more comprehensive booklets designed to inform opinion leaders and similar persons closely interested in the SSI program.

These materials, where appropriate, have been printed in Spanish—and in one case in Braille.

A list of the most important of these publications follows:

SSI Publications

Publication number and title		Quantity
11000	SSI for the aged, blind, and disabled	24, 047, 500
11001	A message about welfare payments	500
11002	SSI: Introduction	52, 500
11003	SSI Guidebook—Introduction	400
11005	SSI Guidebook—Implementation Strategy	400
11006	SSI Guidebook—Public affairs State profiles	400
11007	SSI Guidebook—Fact sheet # 1	400
11008	Questioning the decision on SSI claims	1, 950, 000
11010	Your claim for SSI	5, 100, 000
11011	Import information about your SSI	5, 500, 500
11012	Self-screening leaflet	2, 490, 000
11013	Speakers Guide for SSI	5, 500
11014	Pocket Guide for SSI	2, 000, 000
11015	Introducing SSI	300, 000
11016	Administering the SSI program	10, 000
11017	You will receive an SSI check from the Government every month	4, 200, 000
11024	Important information about your SSI payments	250, 000
11027	Pocket guide to SSI (leaflet)	200, 000
11033	Outline for SSI talks (slides)	25, 000
11034	If you cash U.S. Government checks	10, 000
11035	Your first SSI check	5, 480, 000
11036	A message about your SSI check	3, 101, 000
11038	Project SSI Alert State Supplement card	70, 900
11040	Message to Bankers/Retailers	120, 000
11041	Three lines of defense (labels)	11, 000
11042	Spanish—Three lines of defense (labels)	200

SSI Publications—Continued

Publication number and title	*Quantity*
11090 Spanish—SSI to the aged, blind, disabled	2, 000, 000
10692a Ask us about SSI—poster	40, 000
10692b Ask us about SSI—poster	75, 000
10696 Ask us about SSI—poster	2, 500
Leaflets for 34 States	6, 500, 000

Tailored Information Materials for Each State

The impact of supplemental security income will differ in each of the 50 States because of differences in State payments, rules for Medicaid eligibility, social services offered, and other variations in services available to aged, blind, and disabled people.

Because of these variations, we undertook the unprecedented step of offering a different SSI leaflet for each State and the District of Columbia. These leaflets discuss not only the features of the national program, but the State's special payments and what it has available in the way of Medicaid and other services. In each case the draft copy was to be approved by the State. At present, 34 States have asked us to prepare these specialized leaflets for their citizens, and we have done so.

Project SSI Alert

The Social Security Administration is continuing to work with the Administration on the Aging on Project SSI-Alert, which began late in 1973. The Social Security district office personnel provide technical assistance and support to this volunteer effort. This project was designed to unite a consortium of local volunteer groups in a concentrated effort to reach as many potentially eligible individuals as possible. This endeavor includes an active public information campaign as well as a planned canvassing effort by local volunteers who have been trained to give information and assistance to the people. Reports indicate that the project has been generally successful.

C. Authority To Reverse State Denials

Staff question: ***What is the basis for the assertion that in SSI, unlike social security, the Secretary has authority to reverse denials by State agencies?***

Section 221(c) of title II of the Social Security Act specifically provides that the Secretary may review a determination made by a State agency that an individual is under a disability and, as a result of such review, may make a less favorable determination than the State agency.

However, in enacting the provisions of title XVI, Congress did not impose the restriction upon the Secretary that after his review of a determination made by a State agency, he could only make a less favorable determination than the State agency. Section 1633 of the Social Security Act states—"The Secretary may make such administrative and other arrangements (including arrangements for the determination of blindness and disability under section 1614(a)(2) and (3) in the same manner and subject to the same conditions as provided with respect to disability determinations under section 221) as may be necessary or appropriate to carry out his functions under this title."

This provision allowed the Secretary an administrative latitude that did not exist under the more stringent statutory language in title II. Therefore, when the agreements with the State agencies were modified to have the State agencies process the title XVI disability and blindness cases, the Secretary reserved the right to revise, upon review, a State agency title XVI determination to make it either more favorable or less favorable, as appropriate, where the evidence clearly warranted such a change.

Of course, the prevailing practice in the Title II program of close consultation with the State agency on needed changes is continued under Title XVI, but under Title XVI, the Social Security Administration has the authority to avoid returning case files to the State agency for its formal action when the need for revision is clear, thus avoiding undue delay and unnecessary re-handling in issuing the final decision to the claimant.

Title XVI regulations (Regulation No. 16, Subpart I, Section 416.920) reflects this authority.

D. WELFARE CONVERSION CASES (ROLL-BACK)

Staff question: ***Would you give State-by-State the estimated number of conversion cases who became eligible for APTD after June 1973? Please send us copies of all your transmittals to the State agencies alerting them to the problem and outlining the procedures to be used in dealing with the post-June cases.***

Enclosed are State-by-State estimates of the number of conversion claims that will require a redetermination under Federal SSI criteria as a result of becoming eligible for APTD after June 1973.

An initial EDP screening of the SSR (the supplementary security recipient record) for "conversion" claims first eligible after June 1973, identified some 235,000 claims (accretions through October, 1973) as potentially affected by the rollback provision. Lists of these claims were furnished to the State Welfare agencies (SWA's) for their use in retrieving the claims folders and other evidentiary materials for use by the State DDU's in making the required Title XVI determinations. An additional list of about 35,000 accretions to the APTD rolls in November and December will shortly be sent to SWA's.

Total accounts listed and referred (or to be referred) to SWA's	270, 000
Accretions reported to SSA July through October 1973	235, 000
Accretions reported in November and December 1973	35, 000
Early accretions processed by SWA:	
Referred to DDU's for determinations under federal eligibility criteria through 3/17/74	87, 000
Estimated additional cases to be referred	20, 000
Total estimated referrals	[1] 107, 000
Late accretions:	
Estimated number to be referred to DDU's for federal eligibility determination	[2] 28, 000
Total estimated federal eligibility redeterminations	135, 000

Estimated number of conversion claims eligible after June 1973 (roll-back cases)

United States	135, 350
Boston:	
Connecticut	540
Maine	960
Massachusetts	1, 800
New Hampshire	180
Rhode Island	420
Vermont	360
New York:	
New Jersey	2, 280
New York	27, 360
Puerto Rico	0
Philadelphia:	
Deleware:	
Vocal rehabilitation	180
Blind	0
District of Columbia	420
Maryland	3, 720
Pennsylvania	7, 020
Virginia	2, 520
West Virginia	5, 700
Atlanta:	
Alabama	1, 380
Florida	2, 460
Georgia	2, 940
Kentucky	8, 940
Mississippi	2, 040
North Carolina	2, 820
South Carolina:	
Vocational rehabilitation	1, 260
Blind	0
Tennessee	2, 580

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[1] About 19,000 cases were found to be duplicates or erroneously listed. Early results indicate about half of the remainder of the first 234,000 cases had pre-July 1973 eligibility and consequently were properly converted under PL 93-233.

[2] It is reasonable to assume that a much larger proportion of the late accretions will not have pre-July 1973 eligibility and consequently will require a new determination of eligibility.

Estimated number of conversion claims eligible after June 1973 (roll-back cases)—Continued

Chicago:	
Illinois	7, 680
Indiana	960
Michigan	4, 920
Minnesota	2, 220
Ohio	3, 480
Wisconsin	1, 200
Dallas:	
Arkansas	1, 200
Louisiana	2, 400
New Mexico	840
Oklahoma	1, 740
Texas	3, 810
Kansas City:	
Iowa	420
Kansas	720
Missouri	2, 400
Nebraska	660
Denver:	
Colorado	1, 860
Montana	480
North Dakota	180
South Dakota	120
Utah	120
Wyoming	480
San Francisco:	
Arizona	960
California	10, 140
Guam	0
Hawaii	420
Nevada	0
Seattle:	
Alaska	240
Idaho	360
Oregon	2, 700
Washington	5, 390

TABLE 108.—*SSI regional rollback workload data—week ending June 5, 197[illegible]* [1]

Regions	Total rollbacks					
	Received		Cumulative dispositions			Pending
	This week	To date	Allowed	Denied	Total	
National	1, 760	139, 503	85, 167	32, 361	117, 528	21, 975
Boston	209	6, 828	4, 035	1, 552	5, 587	1, 241
New York	292	28, 798	8, 862	12, 364	21, 226	7, 572
Philadelphia	608	16, 672	7, 864	4, 378	12, 242	4, 430
Atlanta	82	20, 333	16, 996	1, 298	18, 294	2, 039
Chicago	285	21, 000	14, 403	4, 402	18, 805	2, 195
Kansas City	32	5, 177	4, 147	688	4, 835	342
Dallas	16	12, 878	10, 359	1, 506	11, 865	1, 013
Denver	15	4, 184	1, 473	1, 818	3, 291	893
San Francisco	104	13, 920	12, 480	829	13, 309	611
Seattle	17	9, 713	4, 548	3, 526	8, 074	1, 639

[1] Individuals enrolled in State APTD programs after June 30, 1973.

Source: Management Information Branch, Division of Management Information and Planning, BDI.

E. Special Areas of Interest

1. ALCOHOLICS AND DRUG ADDICTS

Staff question: ***How are you administering section 1611(e)(3) (relating to medically determined drug addicts or alcoholics)? What are the problems and accomplishments to date? How many people have been medically determined to be a drug addict or alcoholic and undergoing treatment as monitored by the Secretary?***

Section 1611(e)(3) is interpreted in proposed regulations published in the *Federal Register* (2/2/74) so that an individual will be medically determined to be a drug addict or alocholic if he is under a disability as defined by the Act and drug addiction or alcoholism is a contributing factor to such disability. An individual who is disabled independent of his drug addiction or alcoholism is not determined to be a drug addict or alcoholic under the proposed regulations.

Last year the State welfare agencies identified APTD recipients whose disability was based on drug addiction or alcoholism or who were determined by State medical review teams to be drug addicts or alcoholics. The records of these recipients are being reviewed in each State agency Disability Determination Unit, working with the Social Security Administration, to determine whether they are drug addicts or alcoholics in accordance with the regulatory criteria pursuant to section 1611(e)(3). All new disabled applicants under the SSI program are also evaluated by the State agencies to medically determine if they are drug addicts or alcoholics under the new law. Disabled individuals who are medically determined to be drug addicts or alcoholics are considered for referral to appropriate, available treatment. The State Vocational Rehabilitation agencies are working closely with the Social Security Administration in referring drug addicts and alcoholics to approved treatment facilities and reporting on their treatment in accordance with the Act.

Approximately 40,000 APTD converted recipients were identified by State welfare agencies as possibly being drug addicts and/or alcoholics. Since all of these converted recipients are being reviewed by the State agency Disability Determination Units along with all new allegedly disabled applicants, the evaluation process is incomplete and data are not yet available to indicate the total number of medically determined drug addicts and alcoholics as defined under the new law. However, we infer that the vast number of such individuals will be those converted from State APTD rolls.

In accordance with section 1631(a)(2), the Social Security Administration is providing for representative (or protective) payment to disabled recipients who are medically determined to be drug addicts or alcoholics. Individuals or agencies are selected as representative payees in accordance with criteria generally found most suitable under title II as applicable to the new law. Representative payment is to be made in all States to individuals or appropriate agencies. (In New York, the VERA Institute of Justice, the Health Services Administration and various residential treatment facilities have been selected as representative payees for drug addicts and alcoholics under the care of these agencies.) Only in situations where no suitable individual or agency is available as a representative payee will payment be made directly to medically determined drug addicts and alcoholics for an interim period during which efforts will be continued to find suitable payees.

2. FORMER MENTAL PATIENTS

Staff question: ***What are the procedures being followed in granting SSI disability benefits to former patients of public mental institutions who transfer to an out patient status? Can application for benefits be made when they are still patients? How many people are involved or potentially involved?***

Title XVI provides (section 1611(e)(1)) that no person may be eligible to receive SSI benefits for any month throughout which he is in non-Medicaid status in a public institution. Accordingly, SSA has not encouraged the filing of SSI applications by or on behalf of individuals in public institutions where Medicaid is not paying such individuals' cost of care, since such claims would be denied on this technical basis without a need to develop and determine other factors of eligibility, including disability.

A need has been recognized, however, for SSA to accept and process claims filed by or on behalf of individuals in public institutions (where the institution requests this service) who are ready for release and who, but for their being inmates of the institution, might be eligible for SSI benefits. In effect, this "predetermination" of eligibility, would assist the institutions in their release programs, since they would know in advance whether the individual would have funds available for support. Therefore, special procedures are being established for handling claims of this type. Essentially, the procedures will be as follows:

The institution will identify those individuals who are scheduled for release and will perform certain screening (based on information supplied by SSA) to determine whether there is a high probability of allowance, both from the standpoint of the non-disability and disability factors of eligibility.

If there is a high probability of allowance, the institution will forward full medical documentation and a "lead" form to the district office.

The district office will take a disability application and will formally determine non-disability factors of eligibility.

If the non-disability factors are met, the district office will forward the claim and related material to the State agency for a disability determination.

If the disability requirements are not met, a formal denial will be made; if disability is established, a conditional allowance, contingent upon the individual's release from the public institution within 30 days, will be made.

The institution will be notified of the conditional allowance; when release is accomplished within the time limit, payments may be started.

The anticipated workload has not been determined at this time. Although SSA's regional offices have been asked to provide an estimated workload after contacting States and institutions that have requested this service from SSA, the responses have indicated that definitive figures are not available. It is expected that the institutions will be in a better position to predict workloads after they have reviewed the screening guidelines.

3. PRESUMPTIVE DISABILITY AND EMERGENCY PAYMENTS

Staff question: ***How did the policy of presumptive disability originate in the SSI program? How does it operate?***

Presumptive Disability Decisions

Section 1631(a)(4)(B) of Public Law 92–603 provides for payment of benefits "* * * to an individual applying for such benefits on the basis of disability for a period not exceeding three months prior to the determination of such individual's disability if such individual is presumptively disabled and is determined to be otherwise eligible for such benefits, and any benefits so paid prior to such determination shall in no event be considered overpayments for purposes of subsection (b) solely because such individual is determined not to be disabled."

The report of the Ways and Means Committee states that this provision was included in the law "* * * in recognition of the fact that in some cases additional time is needed to obtain and evaluate medical and other evidence to establish disability, and that a mechanism is needed for meeting living costs during the period in which a formal determination of disability is pending." The report also expresses the expectation that it will be a "rare case" when an individual receiving presumptive payments is found not disabled by the subsequent formal determination.

Case processing guidelines emphasize that presumptive disability decisions should be made only on the basis of evidence that a high probability of disability exists. The State DDU's who work under agreement with the Social Security Administration in making determinations of disability under both titles XVI and II, are primarily responsible for determining when a claimant may be found to be presumptively disabled. District offices have authority to make presumptive decisions in a very limited range of cases where the disabling impairment is clearly observable.

Primary emphasis is given to making presumptive decisions where acute need for financial assistance exists. Expedited efforts are made to obtain evidence for such decisions to the full extent feasible, including the use of telephone communication with medical report sources. Though the major focus is on taking special measures to quickly obtain sufficient evidence to make a finding of PD in situations where acute need is known or can be inferred to exist, the DDU's are authorized to find a claimant presumptively disabled in all other cases whenever in the regular course of development the evidence meets the criteria for making such a decision.

We will be closely monitoring our experience with the presumptive disability concept to evaluate the effectiveness of its application, as well as its contribution to serving the objectives of the program.

[Excerpt from Supplemental Security Income Handbook, § 12751 et seq.]

The Presumptive Disability Decision

A finding of presumptive disability should not be made in any case unless the available evidence, though not sufficient for a final determination of disability, is sufficient to determine that there is a high degree of probability that the applicant is disabled. While the presumptive disability process involves some risk taking, it is expected, as stated in the Senate Finance Committee Report, that it will be a ". . . rare case where an individual later is found not to have been disabled."

In order to assure that presumptive disability decisions are reversed only in rare cases, most presumptive decisions will require a medical judgment based on expeditiously obtained medical evidence. Therefore, the State agencies will have primary responsibility for presumptive disability decisions. DO presumptive disability decisions will be limited to situations where the applicant's allegations are not inconsistent with the observations of the claims representative and provide a high degree of probability that disability will be established.

Determining and Processing Cases of District Office Presumptive Disability

This section covers DO functions for both DO initiated monthly payments and the single emergency advance payment. Additional considerations that apply only to the single emergency advance payment are acovered in § 12753.

Cases Warranting a DO Decision of Presumptive Disability.—DO decisions of presumptive disability will be made only when the applicant's impairment falls within one of the following impairment categories: (1) Amputation of two limbs; (2) Amputation of a leg at the hip; (3) Allegation of total deafness.

When a case is identified as meeting one of the three categories at the initial interview, the case has the potential for a DO determination of presumptive disability. However, even in such cases, do not make a finding of presumptive disability unless either the nondisability eligibility is formally established permitting the initiation of payments for up to three months or the applicant qualifies for an emergency advance payment.

Emergency Advance Payments in Cases of Disability and Blindness

In claims based on disability, emergency advance payment also requires a presumptive or formal disability decision by the DO or SA, but emergency advance payments may be paid without a formal determination of nondisability eligibility. There must, however, be sufficient basis for finding presumptive eligibility on income and resources. In the three impairment categories listed above, the DO may make the emergency advance payment based on their presumptive disability decision.

In addition, since emergency advance payments can be made to blind as well as disabled applicants, the DO may make this presumption of blindness when the applicant with a visual impairment alleges total blindness. The evaluation considerations of § 12752(b) (consistency of observations within the framework of an ordinary claims interview) are the same for allegations of blindness as for the three categories of disability.

This presumption of blindness can be made only when the applicant has a visual impairment and alleges that he is "blind" (i.e., sightless) and the DO representative observes no signs of useful vision (not all visual impairments are considered "blindness" within the meaning of the law).

> Note: Make only an emergency advance payment for those claims in which the DO has made a presumption of blindness. Never make input for presumptive disability monthly payments on the basis of a presumption of blindness; such payments can only be made on the basis of presumptive disability.

Relationship Between Presumptive Disability Payments and Emergency Advance Payments.—Emergency advance payments apply to claims based on disability and blindness as well as age. Thus, there are two special payment provisions for SSI disability applicants, both of which require a finding of presumptive disability.

The emergency advance payment is a one-time advance to applicants against their first month's benefit, payable only if the financial emergency specified in § 13170 exists, which may be based on a finding that the nondisability eligibility factors are only presumptively met; disability may be established either formally or presumptively. In contrast, payments for up to three months can only be made in cases where an individual is found to be presumptively disabled and then only where the nondisability requirements have been formally determined to be met (not presumed to be met).

The title XVI presumptive disability provision for three months of payments applies only to disability applicants (including child claims). There is no provision in the law for three monthly payments based on presumptive blindness; however, the emergency advance payment applies to the blind, as well as disabled and aged applicants who meet the requirements in §§ 13160ff. An applicant who has received an emergency advance payment on the basis of a finding of presumptive disability may also receive up to three months benefits if the nondisability eligibility requirements are established. In this case, the amount of the emergency advance will be offset against the first monthly presumptive disability payment.

4. PAYMENTS FOR MEDICAL EVIDENCE

Staff question: ***What are the supplemental security income and social security approaches with respect to the purchase of or payment for medical evidence? Include a statement of Social Security Administration policy in this area and describe how it was derived.***

Section 223(d)(5) of Title II of the Social Security Act provides that an individual shall not be considered to be under a disability unless he furnishes such medical and other evidence that the Secretary requires. Under this authority, the Secretary requires that the claimant provide any evidence of record from a treatment or examining source as may be needed to evaluate his claim. Any charge made by the source for submitting this record evidence is considered a matter between the claimant and the source. (This is generally in line with the principles of accepted medical practice and the doctor-patient relationship.) Except in rare and compelling circumstances, the government does not pay for evidence of record. Where such evidence furnished by a claimant is not sufficient to enable determination to be made as to his disability, additional medical testing is arranged for and paid by the government.

Under Title XVI, the government does pay for evidence of record in connection with disability and blindness claims if the source charges for furnishing it. This is in accordance with specific congressional direction that it would be unreasonable to expect claimants applying for Title XVI benefits to pay for evidence because of their limited income and resources.[1] As in Title II, the government will also arrange and pay for any medical examinations required to obtain further evidence needed for adjudication in Title XVI if the existing evidence is insufficient to make a determination.

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[1] See page 148, Report 92-231 of House Ways and Means Committee on H.R. 1. Also, page 384 of Report 92-1230 of Senate Finance Committee on H.R. 1.

10. Black Lung—Selected Information

A. IMPACT OF BLACK LUNG ON SOCIAL SECURITY DISABILITY PROGRAM

Staff question: ***Please give a commentary on "Impact of the Black Lung Program on the Social Security Disability Insurance Program with particular emphasis on the appeals process".***

Under the Federal Coal Mine Health and Safety Act, as amended, all black lung program and case-related costs (benefits and administrative expenses) are chargeable to Federal general tax revenues—not Social Security Trust Funds. Thus, from this standpoint, the black lung program has had minimal or no impact on the DI program.

The black lung program has, however, impacted on the disability insurance program in other ways, as follows:

As noted in SSA's Annual Report to Congress on the Black Lung Program, the Act directed the Secretary of HEW to use to the maximum extent feasible, in administering the black lung benefits program, the personnel and procedures used in determining entitlement to DI benefits under Section 223 of Title II of the Social Security Act.

With only a few weeks "get ready" time given SSA by Congress, and in the face of very heavy claims filings under the original law (over 100,000 claims filed in the first month alone (January 1970); 247,000 by the end of calendar year 1970; and over 340,000 through May 19, 1972 (the date of enactment of the 1972 amendments)), SSA found it necessary to shift large numbers of claims personnel engaged in Title II social security retirement, survivor's and disability insurance claims work to taking, developing and processing Title IV, Part B, black lung claims. Additionally, as a result of the 1972 amendments, SSA found it necessary to continue to heavily utilize its Title II claims personnel in handling new claims filed following enactment (over 183,000), and in reexamining and redeveloping cases requiring reprocessing under the amendments' changes (194,000).

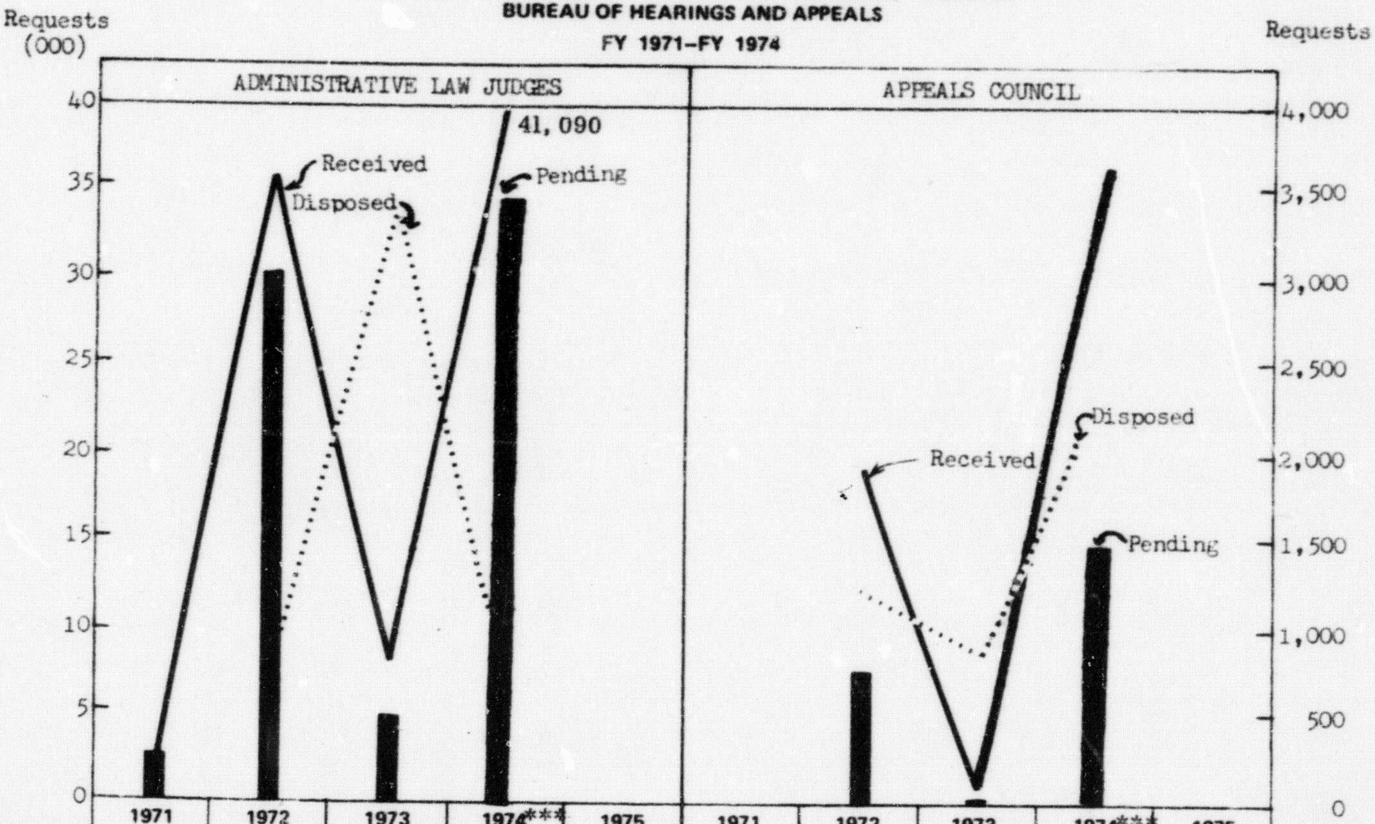
This high volume workload impacted very heavily on BDI headquarters' operations, as well as in district offices, State agencies, and medical sources and facilities involved in Title II claims in States where most of the Nation's coal mining is done (notably Appalachia and other mine areas), with Pennsylvania, West Virginia and Kentucky accounting for approximately 75% of all claims filings (90% if five other coal mine States added).

In BDI Headquarters offices, arrangements were made to reassign a number of trained disability examining and other claims personnel to work exclusively on black lung claims, with new people hired on to assist in processing Title II disability insurance claims. Also, as a means of disposing of the backlog of cases resulting from both the original and amended law, arrangements were made for claims personnel to work a record number of hours of overtime, in addition to regular scheduled hours of work.

Originally, Title IV of the Coal Mine Act provided that SSA would have responsibility for processing Part B claims only through 1972. As a result, SSA staffed up for this workload on this basis. However, in May 1972, Congress extended SSA's jurisdiction of Part B claims (for miners until 7-1-73 and for survivors generally until 1-1-74), added new categories of claimants and more liberal criteria and then required that all previously denied claims be reexamined. The failure to provide sufficient notice to SSA that it was to be the responsible administering agency in December 1969, when the original bill was enacted, as well as the additional workload and continued SSA jurisdiction that resulted from passage of the 1972 amendments caused delays in processing regular social security disability insurance claims both in 1970 and again in 1972 until adequate back-up resources could be assembled.

Black lung filings resulted in greater knowledge of eligibliity for social security disability insurance benefits and contributed to an increase in claims for social security DI benefits.

BLACK LUNG CASES – RECEIVED, DISPOSED, PENDING
BUREAU OF HEARINGS AND APPEALS
FY 1971–FY 1974



	1971	1972	1973	1974***	1975	1971	1972	1973	1974***	1975	
Pending	0	2,326	30,502	4,830		0	0	735	16		Pending
Received	2,326	35,517	7,824	41,090		0	1,888	102	3,560		Received
Workload	2,326	37,843	38,326	45,929		0	1,888	837	3,576		Workload
Disposed	0	7,341	33,487*	11,619		0	1,153	821**	2,077		Disposed
Pending	2,326	30,502	4,839	34,310		0	735	16	1,499		Pending

* Includes 30,600 cases remanded to BDI

**Includes 8 cases transferred to Black Lung Center

*** Through May 25, 1974.

B. CUMULATIVE PAYMENTS

TABLE 109.—*Black lung benefits—Social Security Administration program—Amount of cumulative payments since enactment, and monthly benefits in current payment status, by State, for major coal-mining States*

[In thousands of dollars]

	Cumulative payments (since enactment)				Monthly benefits in current payment status			
	Dec. 31, 1970	Dec. 31, 1971	Dec. 31, 1972	June 30, 1973	Dec. 31, 1970	Dec. 31, 1971	Dec. 31, 1972	June 30, 1973
National	128, 881	532, 610	1, 081, 582	1, 657, 748	13, 041	27, 995	38, 386	53, 160
Alabama	5, 853	24, 503	51, 615	82, 423	529	1, 238	1, 699	2, 534
Illinois	3, 941	25, 437	61, 672	102, 012	429	1, 591	2, 401	3, 674
Indiana			16, 833	30, 367			660	1, 157
Kentucky	8, 418	41, 370	90, 972	155, 658	774	2, 095	3, 193	5, 132
Ohio	2, 423	15, 714	42, 028	71, 753	260	993	1, 690	2, 673
Pennsylvania	65, 892	228, 401	413, 304	582, 148	6, 993	11, 613	14, 385	17, 624
Tennessee	3, 273	15, 660	33, 061	51, 745	317	835	1, 142	1, 625
Virginia	6, 028	27, 056	55, 888	87, 579	578	1, 359	1, 898	2, 721
West Virginia	23, 909	103, 895	209, 386	319, 050	2, 175	5, 251	7, 170	9, 598

TABLE 110.—*Black lung—Social security program data from selected States, as of May 31, 1974*

State	Total applications filed	Applications from miners	Applications from survivors	Cumulative allowance rate (percent)
Kentucky	33, 000	21, 000	12, 000	54. 8
Pennsylvania	120, 800	68, 700	52, 000	75. 5
Virginia	16, 100	10, 200	5, 900	55. 7
West Virginia	58, 900	38, 100	20, 800	58. 7

NOTE.—The overall allowance rate for the program is 62.8 percent. The allowance rate for reconsideration cases is 12.3 percent.

TABLE 111.—*Black Lung—Social Security Administration program*

	Applications filed	Claims allowed	Cumulative payments [1]	Total monthly payment [1]
United States	547, 218	340, 000	1, 657, 748, 381	53, 160, 378
Alabama	27, 561	15, 376	82, 423, 231	2, 533, 662
Alaska	49	21	93, 097	3, 192
Arizona	939	600	2, 822, 194	107, 412
Arkansas	3, 591	1, 974	9, 490, 481	310, 080
California	4, 106	2, 345	9, 796, 570	357, 763
Colorado	4, 349	2, 232	8, 486, 089	300, 855
Connecticut	1, 195	831	3, 925, 349	126, 886
Delaware	562	367	1, 592, 871	53, 885
District of Columbia	359	207	847, 193	29, 921
Florida	5, 054	3, 369	16, 474, 703	584, 319
Georgia	601	349	1, 522, 101	53, 580
Hawaii	13	7	25, 404	1, 958
Idaho	133	67	241, 919	12, 715
Illinois	37, 573	23, 680	102, 012, 394	3, 674, 450
Indiana	14, 136	8, 354	30, 367, 297	1, 157, 358
Iowa	3, 824	2, 504	10, 163, 113	405, 868
Kansas	1, 744	1, 093	2, 537, 169	124, 196
Kentucky	57, 633	31, 405	155, 658, 033	5, 131, 997
Louisiana	192	81	378, 090	20, 029
Maine	22	6	45, 759	2, 043
Maryland	5, 869	3, 635	15, 893, 185	554, 494
Massachusetts	270	134	645, 380	21, 761
Michigan	7, 791	4, 229	16, 276, 138	613, 221
Minnesota	65	39	185, 572	9, 200
Mississippi	171	91	353, 168	18, 386
Missouri	2, 412	1, 234	3, 613, 210	169, 772
Montana	1, 060	571	1, 931, 318	78, 828
Nebraska	62	30	136, 826	5, 703
Nevada	157	103	360, 215	24, 895
New Hampshire	28	15	45, 233	5, 278
New Jersey	5, 150	3, 764	17, 322, 289	568, 978
New Mexico	1, 382	767	3, 284, 919	122, 542
New York	4, 910	2, 938	12, 738, 885	434, 204
North Carolina	1, 518	886	4, 471, 827	161, 214
North Dakota	55	26	153, 934	9, 533
Ohio	31, 943	18, 690	71, 752, 787	2, 673, 228
Oklahoma	2, 771	1, 818	8, 061, 171	289, 914
Oregon	267	159	584, 850	27, 145
Pennsylvania	162, 667	119, 224	582, 147, 519	17, 624, 044
Rhode Island	44	28	121, 236	9, 925
South Carolina	256	166	829, 440	34, 856
South Dakota	19	10	54, 704	3, 064
Tennessee	16, 381	9, 410	51, 745, 534	1, 624, 713
Texas	654	357	1, 536, 845	61, 882
Utah	3, 092	1, 508	7, 009, 388	249, 489
Vermont	14	6	58, 933	2, 256
Virginia	29, 178	15, 558	87, 579, 169	2, 720, 637
Washington	1, 067	594	2, 218, 360	86, 314
West Virginia	100, 496	57, 109	319, 049, 809	9, 597, 741
Wisconsin	311	153	667, 112	26, 166
Wyoming	1, 945	1, 226	5, 581, 667	173, 748
Foreign	1, 577	654	2, 388 772	157, 712

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[1] Through June 30, 1973: December 31, 1973 data is unavailable by State.

C. DENIED BLACK LUNG CLAIMANTS

Staff question: ***Of the denied black lung cases reopened by the 1972 amendments how many have been denied and approved respectively? How many black lung cases are now pending in the social security system short of hearing?***

Out of 191,600 black lung cases reopened (latest corrected count) an estimated 110,000 have or will be allowed. (Nearly all of these cases have had a redetermination under the amendments, but about 5,000 have not yet been tabulated; by March 23, 107,500 allowances and 79,100 denials have been accounted for.)

It is estimated that a determination will be made on virtually all initial and reconsideration cases by August 1, 1974.

Staff question: ***How many black lung beneficiaries have been denied SSDI benefits on grounds other than lack of quarters coverage? What is the appropriate denial rate? How many black lung beneficiaries have been denied SSDI benefits for lack of quarters of coverage?***

Through February 1974, about 203,000 miners have been awarded benefits by SSA under the Federal Coal Mine Health and Safety Act. About 44 percent (89,000) were under age 65 at the time of filing and of this number, an estimated 41,000, 46 percent, have been allowed a DIB. Information on the number who may have filed a DIB claim and been denied is on tape, but has not been tabulated and information on the reason for denial has not been recorded. However, data tabulated in the first 2 years of the program showed that DIB denials amounted to about 12 percent of the DIB allowances. Applying this 12 percent figure to the 46 percent figure described above would suggest that 5.5 percent of black lung beneficiaries were denied SSDI benefits. Also, it should be noted that 48.5 percent of the black lung beneficiaries who were under age 65 did not file for SSDI benefits. (Criteria for "total disability" under black lung program administered by SSA is more liberal than under Title II.)

D. WORKMEN'S COMPENSATION OFFSET

Staff question: ***Explain offset provision in Part B of the Black Lung Law and how it applies. Cover State workmen's compensation attorney fees in this answer. Also explain offset under Part C.***

Under section 412(b) of the Act, Part B benefits payable to a miner or his survivor must be reduced by an amount equal to any payment received by the miner or his survivor under the workmen's compensation, unemployment compensation, or disability insurance laws of his State on account of the disability of the miner. Thus, black lung benefits under Part B are reduced on a dollar-for-dollar basis by the amount of any such State benefits. This reduction applies even though the disability of the miner is not due to pneumoconiosis.

In determining the amount of such benefits received under the pertinent State workmen's compensation law, medical, legal and other expenses incurred by the beneficiary in establishing his State claim, and reflected in his State award, are deducted from the amount of the award. Thus, the reduction made in the black lung benefits is in the amount of the net State award after deducting these expenses (20 CFR 410.520). This policy is consistent with that which is followed under the workmen's compensation offset provision applicable to social security disability insurance benefits (section 224 of the Social Security Act). That policy carries out congressional direction not to include such expenses in determining the amount of the reduction (Senate Committee on Finance, S.R. No. 89-404, pp. 260-261).

The provision for reducing black lung benefits under Part C of the Federal Coal Mine Health and Safety Act, which is administered by the Department of Labor, is different from that in Part B of the law in one important respect. Such reduction is required only if the State (or Federal) workmen's compensation benefits received are based on disability (or death) due exclusively to pneumoconiosis. Moreover, the miner is not required to file for such benefits, as he was under Part B, before black lung benefits eligibility can be established.

In addition to the reductions in black lung benefits that result from the receipt of workmen's compensation benefits, the same workmen's compensation benefits also may require reduction in social security disability benefits to which the individual is entitled. Generally, such reduction is required where the combined disability social security and workmen's compensation benefits exceed 80 percent of the individual's average pre-disability earnings in employment. For this purpose, Part C black lung benefits (like the State workmen's compensation benefits) are considered workmen's compensation benefits. However, Part B benefits (as a result of a change made in the law in 1972) are not considered to be workmen's compensation benefits for purposes of offset against social security disability benefits and thus are not considered in figuring any required reduction.

E. LABOR DEPARTMENT PROGRAM—PART C

(Excerpt from testimony of Nancy Snyder, Associate Director for Coal Mine Workers' Compensation in the U.S. Department of Labor before the General Labor Subcommittee of the House Education and Labor Committee, June 6, 1974.)

* * * * * * *

The Federal Coal Mine Health and Safety Act of 1969 (FCMHSA), charged the Social Security Administration (SSA) with an initial but temporary responsibility for the administration of title IV which provides monthly benefit payments to coal miners who become totally disabled or died from a pneumoconiosis disease or their survivors. In 1972, Congress amended title IV of the FCMHSA by passing the Black Lung Benefits Act, which liberalized eligibility standards and provided payments for medical treatment. The legislation extended benefits to cover all coal miners (not just those in underground mines), and provided benefits for orphans, dependent parents, brothers and sisters, as well as widows of miners who die from pneumoconiosis.

The passage of the 1972 amendments extended the time frame of SSA's responsibilities until July of 1973 and provided for a transition period during which the shift of responsibility for the program to the Department of Labor would occur. This transition period ran from July 1, 1973 through December 31, 1973.

The Department of Labor's administrative responsibilities for the program include the following: 1) to take, adjudicate, and pay claims during the transition period from July 1, 1973 through December 31, 1973, 2) starting January 1, 1974, to continue to take, and make determinations regarding claims, but only pay benefits for claims when a responsible operator cannot be identified and when the State does not have a Workmen's Compensation Program that meets the Federal criteria, 3) to notify coal mine operators of their liability to pay benefits for any period after December 31, 1973, and 4) to adjudicate any differences that the claimant or operator may have with the Department's findings through a system of conferences and formal hearings in which both claimant and operator participate fully. In addition, the Department will administer a compliance program to insure that coal mine operators do not use discriminatory employment practices in dealing with miners who may have the disease in order to avoid subsequent liability for benefit payments. The Longshoremen and Harbor Workers' Compensation Act contains certain provisions which Congress has made applicable to the Black Lung program. The Act sets out procedures for administering a Federal compensation program in which disability benefit payments are assumed by individual employers who are deemed responsible for such benefits. The Act also mandates the insuring of these benefits, calls for the provision of medical treatment and vocational rehabilitation services, and prescribes the hearings and appeals procedures which must be followed.

To administer these responsibilities, the Division of Coal Mine Workers' Compensation, Office of Workmen's Compensation Programs, Employment Standards Administration, has 141 positions which includes a medical advisory staff with the part-time services of a radiologist and an internist having considerable experience in coal mine workers' pneumoconiosis, under contract also are some 800 physicians and hospitals throughout the country providing both diagnostic and treatment services to the Department of Labor claimants and beneficiaries; a control staff utilizing a sophisticated automated data processing system; a branch of Entitlement with its claims examiners; a technical services staff with experience in Workmen's Compensation Programs at the State level and knowledge of the insurance industry including a financial analyst; a payments section for the reimbursement of bills to providers of medical services to claimants as well as for benefit payment computation and the other supportive services such as an inquiries unit for response to Congressional and public inquiries.

Outside of the Employment Standards Administration, other offices in the department have black lung staff responsibility including but not limited to the Office of the Solicitor, the Office of Information and the Chief Administrative Law Judge with his hearing officers.

* * * * * * *

The Department of Labor has received 32,785 claims during the period beginning July 1, 1973, through May 31, 1974, with a total of 39,000 claims expected by the end of the fiscal year, which is 16,000 fewer claims than were projected for fiscal 1974. In addition, in fiscal 1975 we expect to receive 38,000 claims; 15,000 claims in fiscal 1976, dropping to 6,000 claims in fiscal years 1977 and 1978, and leveling off at 5,000 claims annually in fiscal years 1979, 1980 and 1981. Approval rate for the initial 6,791 claims reviewed is fluctuating around 20%. Of the 32,785 claims filed to date, only 3,077 are refilings for medical benefits from claimants who are receiving black lung benefits from the Social Security Administration, representing only 1.5% of the living miner claims approved by social security. We anticipate receiving an additional 2,423 refilings by the end of fiscal year 1975. The statute of limitation in part C will preclude almost all refiling after this time. The medical costs attributable to the refiled claims will average $3.4 million annually. In testimony earlier this year before this subcommittee, the coal industry estimated medical costs of nearly two billion dollars based on a projected rate of refiling of 50% of the living miners receiving benefits from SSA. Actual experience does not support the industry projections.

We estimated that the total amount of Department of Labor benefits payable through 1981 will be approximately $500,000,000. While initial projections had forecast an eighty percent (80%) responsible operator identification, recent trends are significantly below this figure. The industry has testified that the Federal black lung program will cost approximately $25 per $100 of payroll. The latest data that we have received from the National Council on Compensation Insurance reflects an average premium cost for underground coal miners of $17.90 per $100 of payroll and $5.88 for surface mines in the twenty-five States serviced by the National Council. It should be pointed out that the major coal-producing States of Pennsylvania, Ohio and West Virginia have rates significantly below those of the National Council States. Pennsylvania has a rate for both underground and surface mines of $3.61; Ohio has a $3.68 rate for surface and a $6.30 rate for underground; and West Virginia has a $3.58 rate for surface and a $7.15 rate for underground mines.

The insurance industry has responded to the need for insurance coverage for the black lung liability. We have received verification from thirty-seven (37) private insurance carriers and three (3) State Funds reflecting coverage written in each of the thirty (30) coal mining States on one thousand nine hundred ninety-five (1,995) coal operators. In addition, sixty-three (63) coal operators have been approved to self-insure or are pending approval, representing fifty (50) percent of the active mining population. When self insurance is combined with insurance afforded by the private carriers and State Funds, we estimate that ninety-five percent of the active mining population are now covered under the insurance provisions of the Federal Act.

* * * * * * *

11. Private Disability Insurance Protection

The staff asked the following questions concerning private disability insurance protection of both the Social Security Administration and the American Life Insurance Association.

Staff questions: ***Please describe the extent of private disability insurance protection? How many people have disability coverage under private pension trust which are approved under IRS regulations? Give the types of disability plans so provided. How extensive is individual and group protection under private insurance contracts? In what manner are the social security offset provisions in these contracts publicized?***

It has been stated that the following is one of the most popular disability insurance plans:

> ***Disabilities would be covered commencing with the 6th month of disability providing the individual could not perform the duties of his occupation. After 2 years, the disability would continue to be covered if the individual could no longer perform the duties of any occupation.***

What has been the experience with this type of plan? How many people lose their benefits when, after 2 years, the occupational definition is no longer available?

A. Answer From the Social Security Administration

Disability protection is generally classified by duration into two types: (1) sickness insurance and sick-leave plans for short-term disabilities; and (2) long-term disability insurance, and disability provisions of retirement plans for long-term disability. Most often the first six months are considered short-term, and beyond that long-term. But not all income maintenance plans adhere to this division, e.g., some private insurance policies offer benefits from the beginning of a disability for up to a whole year; conversely, the OASDHI program pays for long-term disability beginning with the sixth month.

With respect to short-term disability, more than thirty million wage and salary workers in private industry were covered by private group accident and sickness insurance or sick-leave plans in 1972. However, excluding seven million workers from this total whose private plans are established under requirements of State temporary disability insurance laws, a little over twenty-two million or almost half of the wage and salary workers in the remaining States have this protection through voluntary arrangements.

Besides the short-term group disability protection available to workers through their employment, many people purchase individual policies to provide income when sick or hospitalized. An unduplicated count of the number of individual policyholders who have this protection and who are not also counted in the above estimates for group protection is not available. Benefit payments may be useful as a gross indicator of extent of protection. In 1972, accident and sickness insurance through individual insurance paid $785 million or about one-tenth of the total of benefits paid through group plans in private industry plus individual policies.

Private protection against long-term or permanent disability may be provided as part of a pension plan and/or directly through disability insurance. On the basis of a survey by the Department of Labor (as of 1962–63), about 70 percent of the workers covered under private pension plans are in plans with disability retirement provisions. A more recent study (1965–70) made by the Bankers Trust Company of New York and based on industrial retirement plans which covered about 7.8 million employees showed 77 percent of the plans had disability retirement provisions. With about 27.5 million workers estimated to be covered by private pension plans at the end of 1972, it may be assumed that about twenty million had disability protection through their pension plan.

Group long-term disability insurance policies covered [illegible] million workers in 1972. Some of these workers were probably also covered by disability provisions in their pension plans. Altogether, then, it may be estimated that roughly twenty-five million wage and salary workers, or about two-fifths of the wage and salary labor force, have protection against the risk of long-term disability through nongovernment arrangements. Individual policies are also sold for long-term disability protection, but estimates are not available on the number of workers under such policies with no other coverage against the risk.

Under the Social Security Act, the definition of disability is "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." The main difference in the definition of disability under private pension plans and under the Social Security program is the extent to which an applicant must be disabled. Based on the Department of Labor survey, about 6[illegible] percent of the workers covered under private pension plans which have disability provisions are required to be disabled to the extent that they cannot perform any job. In the remainder of the plans the definition of disability is discretionary or requires only that the worker be unable to perform a job for which he is qualified or any job in the company or industry.

The 1970 Bankers Trust study showed that about 81 percent of the plans with disability retirement provisions are without any age requirements but about four-fifths of these plans require ten years or more of service. The typical plan now requires about ten years of service, a liberalization since 1965 when the Bankers Trust study showed that the typical plan required 15 years of service.

The 1970 Bankers Trust study also showed that among the plans with disability retirement provisions, only about one-tenth limited the pension to the actuarial equivalent of the normal accrued benefit for life. The others paid a normal accrued benefit without actuarial reduction—payable for life. More than half of these plans provided for an additional benefit payable to the start of social security benefits which in some cases amounted to more than twice the normal accrued benefit.

Many group long-term disability insurance plans have a two-stage definition of disability, requiring a greater degree of disability for continued benefit eligibility after the first two years. No data have been published on the number of workers who lose their benefits after two years because of the application of stricter disability requirements. It is estimated that two-thirds of group disability insurance beneficiaries also receive OASDHI disability benefits. These beneficiaries for the most part can be expected to have severe enough disabilities to meet the second more stringent definition of disability as well as the first. Unfortunately, these estimates do not show separately the experience of claimants before and after the stricter disability definition is applied.

Disability benefits are often offset by amounts of public disability benefits payable, especially under OASDHI and workmen's compensation. The 1970 Bankers Trust study showed that these offsets are applied in about one-third of the private pension plans.

Most group long-term disability contracts also provide for offsetting OASDHI disability benefits, either in full or in part (usually to the extent that combined benefits exceed a specified proportion of previous earnings).

The extent to which social security offset provisions are publicized in disability insurance contracts is not known. One general way of publicizing provisions is for employers to prepare pamphlets for distribution to workers. For example, according to the February 1969 *Employees Benefit Plan Review*, plan booklets of the Coca-Cola Bottling Company of Los Angeles and the Southern States Cooperative specifically describe their offset provisions.

B. ANSWER FROM THE AMERICAN LIFE INSURANCE ASSOCIATION

What is the extent of private disability insurance protection?

Individuals have protection against wage loss through disability in the form of insurance which provides either short-term (two years or less) or long-term (more than two years) coverage. In addition, many employers have either formal or informal paid sick leave plans (usually short-term).

In the field of long-term disability insurance, group insurance contracts provide benefits as high as $1,500 per month payable to age 65 in the event of illness or accident. Some plans provide life-time benefits for disabilities. The benefit commonly provided is 60 percent of wages, usually reduced by disability income benefits received from such other sources as Social Security, Veterans' Administration, Workmen's Compensation or from group pension plans.

Individual long-term disability insurance policies are sold with a wide choice of benefit limits and payment periods. Benefits may range from $50 per month to $1,000 or more. Benefits are limited to not more than a specified percentage of earnings, usually in the range of 50 percent to 75 percent. Common periods for benefits to be payable are 2, 3, 5, and 10 years and to age 65, depending on what the individual wants to purchase. Benefits may commence anywhere from seven days to one year after the onset of disability, again depending on the choice of the buyer.

In the field of short-term disability insurance, group insurance plans usually provide for benefits equal to a fairly high percentage of an employee's wages, beginning after one week of total disability. The most common benefit periods are 13 and 26 weeks.

In the case of individual short term disability insurance policies, benefits are usually payable after seven days of disability for a period ranging from six months to two years. The amounts of such benefits fall in a wide range, reflecting the income of the purchaser.

The extent of protection against wage loss due to disability is reported annually in the "Source Book of Health Insurance Data", prepared by the Health Insurance Institute. (See Attachment A.) During 1972, the civilian labor force in the United States included about 82 million employed persons. Of this group, over 60 million had protection against short term disabilities through insurance or formal sick leave plans. A great many of the remaining 20 million had some protection through informal sick leave plans or are covered by insurance under long term disability insurance plans. The most recent report along these lines (Attachment B) was released by the Health Insurance Institute on April 11, 1974.

How many people have disability coverage under private pension trusts which are approved under IRS regulations? Give the types of disability plans so provided.

Unless such information could be obtained by the IRS, there is no source of statistics to answer this question. Pension plans generally provide two types of disability benefits. The first type is cash payments, which may consist of simply providing an early pension or may be a scheduled benefit payable to age 65 or for a specified period. At the end of the period of disability payments, the normal pension may commence. Under the latter approach, the disability payments may come directly from a pension fund, be payable from another trust fund or be covered by an insurance contract. A great many groups covered by a pension plan will have disability payments provided outside the plan.

A second type of disability benefit provided by pension plans is to continue to accrue pension credits for disabled employees so that they will be eligible for a full pension at normal retirement age. Incidentally, group life insurance policies commonly provide disability benefits in the form of waiver of premium, but some contracts provide for cash payments.

How extensive is individual and group protection under private insurance contracts?

As of the end of 1972, 33 million people were insured under group contracts against short-term disability and 12.5 million people were insured under individual contracts against short-term disability. Some people had both individual and group coverage, so that a total of 42 million people were insured against short-term disability. At the same time, 8.5 million people were insured against long-term disability under group insurance contracts and 4 million people were insured against long-term disability under individual contracts. Aggregate benefits paid in 1972 under all these contracts, group and individual, short-term and long-term, amounted to $2 billion.

In what manner are the Social Security offset provisions in these contracts publicized?

Where group insurance plans are integrated with Social Security, the details are spelled out in contracts and certificates. Employees are given, in addition, booklets or pamphlets written in easily understood terms. Such materials are given to employees when they enroll in a plan and are periodically updated. It should be noted that the most common group short-term disability plans are for benefits of 13 or 26 weeks and are not, therefore, integrated with Social Security since Social Security benefits begin six months after disability occurs.

In the case of individual insurance policies, the provisions of the policy are normally explained by the agent during the sales interview or when the contract is delivered, or both.

It has been stated that the following is one of the most popular disability insurance plans:

> ***Disabilities would be covered commencing with the sixth month of disability providing the individual could not perform the duties of his occupation. After two years the disability would continue to be covered if the individual could no longer perform the duties of any occupation.***

What has been the experience with this type of plan? How many people lose their benefits when after 2 years, the occupational definition is no longer available?

The differences between various types of tests to determine total disability show up both in differences in contract language and in differences in administrative practices among insurance companies. The differences can be illustrated by considering their application to a surgeon who suffers an accident or an illness. If he is unable to perform surgery, benefits will be payable under a clause defining disability in terms of inability to perform the duties of "his occupation". If he were able to function as an internist, as a general practitioner or in some other comparable medical profession, benefits would be paid if the test were "his occupation" but would not be paid if the test were "any occupation for which he is resonably fitted by education, training and experience". If the individual was confined to a sanatorium, but was able to perform a limited job such as working on the sanatorium grounds, for which he was paid, benefits would continue to be payable under either of the above two definitions but would not be paid under a definition of total disability in terms of "inability to perform the duties of any occupation".

Historically, early definitions of total disability in life insurance policies and in disability insurance policies used "his occupation". This led to numerous claims being paid to claimants who were unable to perform all duties of their occupation but whose earning power was not substantially impaired. In 1929 the National Association of Insurance Commissioners prohibited the use of this definition in life insurance policies although not in disability insurance policies. Thereafter, disability insurance policies generally provided for a limited period of "his occupation" followed by "any occupation." Subsequently, policies were written under which "any occupation" clauses were modified by adding a phrase such as, "for which he is reasonably fitted by education, training and experience". The trend in recent years has been to extend the period for which the test is "his occupation". It should be noted that under group short-term disability policies clauses drafted in terms of "any occupation" are often administered as if they were "his occupation". This practice is not carried over into group long-term disability insurance. (See Attachment C for discussion of group long-term disability insurance practices.)

The variations in contract language and administrative practice make it impossible to give a general answer to the question concerning the number of people who stop receiving benefits when the definition of disability changes from "his occupation" to something more restrictive. However, the Health Insurance Association of America checked with some of the larger writers of health insurance and found that for these companies, approximately 10 percent of persons receiving disability benefits stop receiving benefits when the definition of disability changes.

Some additional insight into the problem of how to define disability is provided by a statement made by George W. Chalmers, Vice President of the Confederation Life Insurance Company of Toronto at a meeting of the Society of the Actuaries in 1969. (See Attachment D.)

ATTACHMENT A

Loss of Income Protection

Loss of income (or disability income) protection is designed to provide wage earners with regular weekly or monthly cash payments in the event that wages are cut off as a result of illness or accident. This coverage may be in the form of short-term or long-term protection. (Short-term policies are those with maximum benefit periods up to 2 years; long-term plans have benefit periods greater than 2 years.)

At the end of 1972, 73 million persons were protected by some form of disability income coverage. Over 61 million persons in the United States were covered by short-term loss of income protection through insurance company plans or other formal arrangements, a 4 percent increase over 1971.

Some 42 million workers were protected under insurance company short-term disability income policies at year-end 1972; 33 million of these persons were covered by group policies and 13 million were protected by individual plans. About 3 million persons were protected under both group and individual plans.

The number of persons protected against short-term loss of income through formal paid sick-leave plans of private industries and plans for civilian employees of government rose 1 million during 1972 to 18 million by the end of the year. Over 1 million persons were protected by other plans.

Some 13 million persons were covered by long-term disability policies of insurance companies. The number covered increased 6 percent during 1972. Some 9 million were covered by group policies at the end of the year, and 4 million were protected by individual policies. Some 1.3 million persons covered by long-term disability policies also have short-term coverage.

TABLE 112.—*Number of persons with disability income protection, by type of program in the United States*

[In thousands]

End of year	All programs	Insurance companies: All insurance companies	Insurance companies: Group policies	Insurance companies: Individual policies	Formal paid sick leave plans	Other
1946	26, 229	14, 369	7, 135	8, 684	8, 400	3, 460
1950	37, 793	25, 993	15, 104	13, 067	8, 900	2, 900
1955	39, 513	29, 813	19, 171	13, 642	8, 500	1, 200
1960	42, 430	31, 836	20, 970	14, 298	9, 500	1, 100
1961	43, 055	32, 055	21, 186	14, 301	9, 900	1, 100
1962	44, 902	33, 602	22, 313	14, 854	10, 200	1, 100
SHORT-TERM DISABILITY INCOME PROTECTION						
1963	44, 475	32, 475	22, 669	12, 902	10, 900	1, 100
1964	45, 270	33, 270	23, 177	13, 280	10, 900	1, 100
1965	49, 690	34, 160	24, 615	12, 559	11, 700	1, 100
1966	50, 003	36, 403	26, 322	13, 264	12, 500	1, 100
1967	51, 915	37, 515	27, 632	13, 004	13, 300	1, 100
1968	55, 677	40, 777	30, 229	13, 879	13, 800	1, 100
1969	57, 627	41, 027	30, 865	13, 807	15, 500	1, 100
1970	57, 833	40, 833	31, 498	12, 683	15, 900	1, 100
1971	58, 850	41, 250	32, 168	12, 340	16, 500	1, 100
1972	61, 106	42, 346	33, 103	12, 559	17, 660	1, 100

TABLE 112.—*Number of persons with disability income protection, by type of program in the United States*—Continued

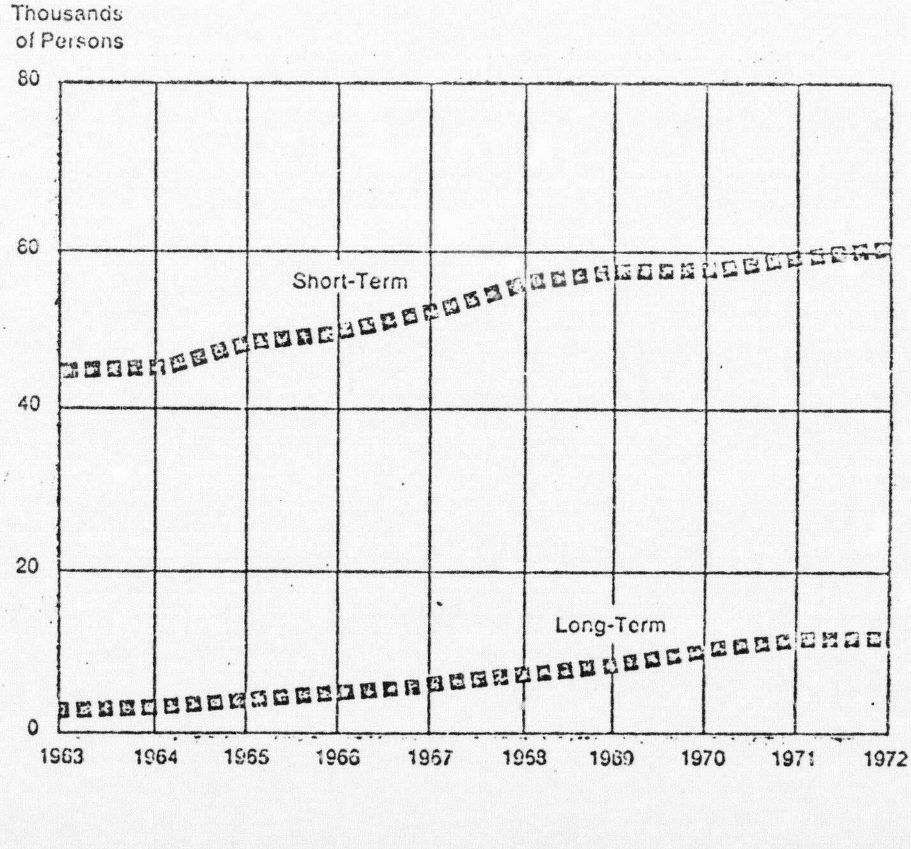
[In thousands]

End of year	All programs	Insurance companies			Formal paid sick leave plans
		All insurance companies	Group policies	Individual policies	
LONG-TERM DISABILITY INCOME PROTECTION					
1963	3, 029	3, 029	749	2, 280	------------------
1964	3, 420	3, 420	1, 257	2, 163	------------------
1965	4, 457	4, 457	1, 903	2, 554	------------------
1966	5, 002	5, 002	2, 376	2, 626	------------------
1967	6, 682	6, 682	3, 827	2, 855	------------------
1968	7, 718	7, 718	4, 710	3, 008	------------------
1969	9, 076	9, 076	5, 715	3, 361	------------------
1970	10, 740	10, 740	7, 176	3, 564	------------------
1971	12, 011	12, 011	8, 209	3, 802	------------------
1972	12, 774	12, 774	8, 595	4, 179	------------------

Note: Data in the category "Insurance companies" refer to the net total of people protected, *i.e.*, duplication among persons who are covered by both group and individual policies has been eliminated. Any duplication resulting from the combination of numbers covered for short-term and long-term protection has not been eliminated. The category "Formal paid sick leave plans" refers to people with formal paid sick leave plans but without insurance company coverage. The category "Other" includes Union-administered plans and the Federal Mutual Benefit Association.

Source: Health Insurance Council.

NUMBER OF PERSONS WITH DISABILITY INCOME PROTECTION
In the United States



ATTACHMENT B

[From Institute of Health Insurance, April 1974]

4 of 5 Workers Have Income Coverage

Although eight out of every 10 people in the nation's labor force have some form of disability income coverage, two out of 10 still do not, leaving themselves open to a financial hazard, reports the Health Insurance Institute.

Family money counselors stress that a working person is not adequately protected—no matter how fully the medical bills may be insured—unless there is money also coming in to pay continuing expenses such as food, mortgage, rent, utilities.

The seriousness of the gap is shown, said the Institute, by a U.S. Bureau of the Census report that, in a year's time, one out of 10 family heads between the ages of 18 and 64 is likely to be disabled seriously enough to hinder them in their employment.

Not good odds

This means that the odds of a worker without disability insurance being disabled are too high to continue unprotected, said the Institute.

Disability income coverage has been growing, said the Institute. At the start of 1974, an estimated 63 million people had short term policies with insurance company plans or other formal arrangements, while 14 million had long term protection exclusively with insurance companies. Five years earlier, the figures were, respectively, 56 million and eight million.

Disability benefit payments by insurance companies have also grown, from $1.4 billion in 1968 to an estimated $2.1 billion in 1973.

Short term disability insurance protects for periods of up to two years while long term protects beyond two years through a person's lifetime. Many persons are covered for both kinds.

The Institute also pointed out that disability income insurance usually covers a person for between 50 to 60 per cent of his gross income during the time he is unable to earn an income.

ATTACHMENT C

Long-Term Disability Income

(By Morton D. Miller, executive vice president and chief actuary, Equitable Life Assurance Society of the United States, from L & H Insurance Handbook)

Definition of disability

In defining the contingencies covered, long-term disability income policies often make a distinction between disability which prevents the pursuit of the person's usual occupation and disability which results in the inability to perform any work for compensation. Thus, one frequently used provision defines disability with respect to an initial period, such as two years, as the inability of the employee to perform "any and every duty pertaining to *his occupation*." If disability continues beyond the two-year initial period, further payments are then conditioned on the more stringent test that the disability must be of sufficient severity to prevent the claimant from engaging in *any* employment whatsoever. In this way, if a claimant recovers sufficiently to be able to do some work, he may be expected to accept a job in any occupation that he is capable of performing. Otherwise, his payments would terminate.

Unlike short-term disability policies, most long-term policies provide coverage for both nonoccupational and on-the-job accidents and sicknesses, supplementing workmen's compensation insurance in the latter case. Long-term income policies usually do not provide maternity benefits, however.

Duration of benefits

Long-term disability income benefits normally start after short-term benefits or uninsured wage or salary continuance payments cease. Sometimes they precede or may supplement disability income payments under pension plans.

In order to integrate benefits with such plans, the long-term disability income policy usually has a long waiting period, at least equal to the benefit period under the short-term benefit plan (or earnings continuance plan); a six-month period is common in such instances. Even where the long-term plan is the only disability benefit, it is likely to have a substantial waiting period, such as 30 or 90 days.

There is a wide variation in the maximum duration of benefits. Some policies have a maximum period as short as two years; some provide benefits until the individual reaches normal retirement age; and a few have a lifetime benefit, at least for accidents. Durations of five years, 10 years and to age 65 are the most common. Some plans may vary the duration for different classes of employees, such as by providing a longer maximum duration for those with more years of employment.

Choices among these possibilities depend upon the other provisions which the employer may make for disability protection (e.g., under a retirement plan) and are sometimes influenced by a collective bargaining agreement. Costs, the nature and duration of employment, and the patterns in the particular industry are other factors that must be considered.

Amount of benefits

Under group long-term disability income policies, the benefit amount, usually payable monthly rather than weekly, is determined in accordance with the same principles as were outlined for short-term disability income policies. But some additional considerations enter the picture. One of them is that this form of benefit has been provided extensively for higher paid employees and, therefore, the maximum amount often is considerably higher than for temporary benefits. Many plans have a maximum benefit of $1,000 or $1,500 a month, and some provide amounts as high as $3,000 a month.

However, care is taken to assure that the monthly benefit amount is significantly less than the individual could earn (net after taxes) if he were working. This means the benefit should not be much greater than 60 percent of normal gross earnings, and preferably no more than 70 percent of net earnings. Such a limitation takes on added importance in connection with long-term benefits because of the larger benefit amounts involved, especially for those with higher incomes whose taxes reduce their gross incomes substantially. Table 27–5 illustrates the relationship to net earnings of a long-term disability benefit at the level of 60 percent of gross income.

A further important consideration is the extent to which the claimant may be entitled to other disability income. Account must be taken of workmen's compensation, social security, veterans' pensions, employer's pension plan disability benefits, and individually purchased disability income policies. For long-term benefits, the large amounts and extended durations of payment require "integration" with these other benefits in order to avoid making the total of the disability payments from all sources overly attractive as compared with normal earnings. The usual procedure is to provide that benefits from other sources will serve to reduce the long-term benefits otherwise payable under the group policy.

TABLE 113.—*Relationship of Long Term Disability Benefit to Net Earnings*

Monthly gross income	Net earnings [1]		60 percent of gross income	Ratio of 60 percent of gross income to net earnings	
	Single	Married [2]		Single	Married [2]
$400	$356	$377	$240	0.67	0.64
$800	681	717	480	.70	.67
$1,200	982	1,047	720	.73	.69
$2,000	1,521	1,681	1,200	.79	.71

[1] Gross income less estimated 1970 Federal income tax without adjustment for surtax.

[2] Family assumed to consist of employee, wife, and 1 child under age 18, filing a joint tax return.

Long term disability plans frequently include a supplemental benefit during the employee's period of disability in an amount sufficient to provide for the continuing accrual of benefits under a companion retirement income plan. This benefit, usually referred to as a "pension accrual benefit," may provide for a supplemental payment to the pension plan on behalf of the disabled employee. Alternatively, the long term disability policy may provide payments commencing at normal retirement date, if the employee is still disabled, in an amount sufficient to provide the difference between the employee's actual retirement benefit and what his retirement benefit would have been had he not become disabled.

Some modifications of the usual long-term disability benefits, still somewhat experimental, attempt to recognize that along with other fixed income amounts, the monthly income tends to become increasingly inadequate as price and wage levels rise over the years. One procedure is to ignore any increases in social security benefits (which would otherwise be subtracted from plan benefits) after the long term payments commence. A more direct method is to adjust the monthly income amount periodically in accordance with changes in the consumer price index. Adjustments are usually limited to, say, 3 percent in any one year, and it is usually provided that the benefit will not be reduced below the original benefit amount because of the changes in the index.

Many insurers include in their long-term plans a rehabilitation provision to permit a trial work period, such as one year, during which benefits are continued but reduced by some amount, perhaps 50 percent of the employee's earnings from rehabilitative employment. The disabled employee who is anxious, but not yet confident of his ability, is encouraged to return to active employment. If the trial work period indicates he is not yet capable of working, his long term benefit period will not be terminated by reason of accepting employment and he will not have to resatisfy the waiting period.

Integration with social security

Social security benefits currently are available without age restrictions for all insured workers. The disability need not be permanent, but need only prevent the worker from engaging in any substantial gainful employment and be expected to last for at least 12 months. In this case, the worker qualifies for benefits which become payable after a six-month waiting period.

Social security benefits are based on the average of the individual's monthly earnings which become subject to social security taxes. During 1971, social security monthly benefit awards to disabled workers averaged about $152, with a corresponding maximum family benefit award of about $235. Benefits were increased 20 percent in 1972, so that the maximum monthly benefit in 1972, effective September 1, for an individual worker can be as much as $331 and for a family (including the worker) as much as $579.

Since the social security program covers essentially the entire work force and during disability replaces a substantial portion of current income, particularly for workers earning less than $750 monthly, it cannot be ignored in designing and administering long-term disability plans. Thus, the long-term disability benefits payable generally are offset by the amount of benefits payable under the social security program.

In order to encourage the employee to apply promptly for such benefits, it is common to provide that the long-term benefit automatically will be reduced by an estimated social security benefit until proof of the actual amount is established. For lower-paid employees, the operation of the social security offset may result in a very small long-term payment, or no payment at all. In order to avoid this situation, some plans exclude from eligibility employees earning less than a minimum amount, such as $750 per month. Other plans which include all employees regardless of earnings may provide a minimum long-term disability benefit, such as $25 per month, or may require no employee contribution on the first $650 of monthly earnings.

Exclusions and limitations

Limitations on long-term disability benefits under group policies are remarkably few. Except for smaller groups, group policies usually do not exclude causes of disability which predate the effective date of the insurance.

Also, unlike short-term policies which normally are limited to nonoccupational causes of disability, long-term disability policies almost always provide coverage for occupational causes because the long-term benefit level is often substantially greater than workmen's compensation. The policy is written in such a manner as to make the long-term benefits supplemental to workmen's compensation; the amount of the long-term payment is reduced (through the integration provision) by the amount of workmen's compensation benefit payable. Group policies ordinarily include coverage for disabilities due to alcoholism, drug addiction, or nervous and mental diseases. It is customary, however, for long-term policies to exclude disability from self-inflicted injuries, an act of war, or participating in or committing a felony.

Termination of coverage

Most long-term disability policies permit the insurer to terminate the policy on any anniversary date, though this provision is seldom employed. As in the case with other forms of group insurance, the insurer may terminate the policy on any premium due date when the number of covered employees drops below a specified minimum, such as 25, or the percentage of those insured is less than a stated amount, usually 75 percent of the number eligible. The employer usually can terminate the policy on any premium due date and, of course, except as provided in the 31-day grace provision for payment of premium, the policy will terminate on default of payment of premium.

As is the case with short-term disability coverage, and for the same reasons, an employee's long-term disability insurance coverage ordinarily terminates upon cessation of active employment.

ATTACHMENT D

[Statement Made by George W. Chalmers, Vice President, Confederation Life Insurance Co., Toronto, Canada, at Meeting of Society of the Actuaries, 1969]

I think we need to take a hard look at the suitability of our product. I can understand a definition of disability which allows for payment during the first 2 years in which the man is unable to follow his own occupation, but I do not really see the need to use the common clause today which allows the man to draw benefit during the first 5 years in which he is unable to follow his own occupation and, thereafter, to draw benefit while he is unable to follow any occupation for which he is reasonably fitted by education, training, or experience. Some companies now have a 7-year own occupation or a 10-year own occupation or a 10-year own occupation clause, and to my mind, once you have got as far as 5 years, it does not really matter whether you quote a 7- or a 10-year clause.

Also it appears to me that roughly half the companies qualify a man for payment if he is unable to follow his own occupation and do not seem to care whether he is able to follow any other occupation. The other half of the companies will qualify a man for payment if he is unable to follow his own occupation but then will not pay him if he follows any other occupation. It seems to me that the first 50 per cent are insuring a sickness status and are completely forgetting the principle of indemnity, whereas the second 50 per cent remember the principle of indemnity but forget the public need, since they cut the man off completely if he earns at all. I wish to quote now from the "Definition of Disability" contained in a policy issued by a United Kingdom office. I am choosing a United Kingdom office not because I happen to come from the United Kingdom myself but rather because I wish to avoid quoting any one North American company as an example to this audience.

This United Kingdom definition reads:

> For benefit to be payable, the member must be totally incapacitated, by reason of sickness or injury necessitating medical or surgical treatment, from returning to the occupation in which he was engaged immediately prior to becoming so incapacitated and not be following any other occupation or employment; and must be certified to be so incapacitated by a medical adviser appointed or approved by the company. If at a later date not less than 2½ years after first becoming incapacitated, and while remaining totally incapacitated from follow-

> ing the occupation in which he was previously engaged, the member, in the opinion of the medical adviser appointed by the company, becomes capable of following some other occupation for which he is reasonably fitted by training, education or experience, the entitlement to benefit shall be reduced to a partial basis related to the company's assessment of the loss of earnings (if any) in relation to his former occupation to be expected if the member engaged in such other occupation.

Although this still has the effect of stopping the man from working at all during the first 2½ years, thereafter it automatically allows for adjustment of the sickness income payable in accordance with the loss of income experienced, and this is more truly the principle of indemnity. It also has the advantage of embracing the partial disability situation and the rehabilitation situation whereby small earnings in rehabilitative employment can be enjoyed without seriously affecting the indemnity income. I am aware that the precise wording of this clause might not meet with approval in some states, but I believe that the principle followed is the correct one.

12. Attorneys' Fees[1]

BACKGROUND

The issue of attorney fees in Federal income maintenance programs has been raised sporadically during recent years. Recently, the problem was an issue during the hearings of the Subcommittee on Representation of Citizen's Interest of the Senate Judiciary Committee on September 19, 20, and October 1-5, 1973 where allegations of unduly high fees were discussed at length. In previous years Congressional attention had been directed primarily at allegations that various governmental agencies had set attorney fees so low that adequate representation had been impaired. Agencies administering such programs as Black Lung, Social Security, and Longshoremen and Harbor Workers' Compensation have statutory authority to set fees based on maximum percentages of benefits that can be paid or certified for payment to claimant's attorney. Such fee limitations have been long accepted as within the authority of Congress to set. (See *Calhoun* v. *Massie*, 253 U.S. 170 (1919).)

SOCIAL SECURITY FEES

In 1960 the Subcommittee on Administration of the Social Security Laws of the House Ways and Means Committee in its hearings explored the problem of the Secretary of HEW setting a fee in Social Security Disability cases that was too low to attract many lawyers. In commenting on the $10 fee then allowed without a petition for lawyers in these cases Representative Harrison said, "The Supreme Court in my State of Virginia has said that a lawyer's services are worth what they are paid for." It was found that because of the fee limitation attorneys were hard to obtain and even when they were retained they arrived at hearings unfamiliar with the program and inadequately prepared to represent their clients.

After the Subcommittee's hearings the fee schedule was revised to allow attorneys to collect a $30 fee without submitting a petition and the Subcommittee stated that it hoped that the new, still relatively low, fee schedule would increase the frequency and quality of representation.

During the Subcommittee hearings Earl Kintner of the Administrative Law Section of the American Bar Association had stated that there were two alternatives; either fees should be increased or restrictions on the fees might be lifted entirely.

This latter alternative was explored by the Senate Judiciary Committee which in 1966 reported a bill introduced by Senator McClellan (S. 1522). This bill would have eliminated the authority of a governmental agency to regulate attorney fees subject only to a provision giving the agency an appeal before a court if it believed a fee was unreasonable. An attorney would have been required to file with the agency the amount of fee charged. If the agency felt that the fee was excessive it could negotiate with the attorney for 90 days. If at that time the agency was still not satisfied with fee charged, it could file a petition with the U.S. district in which the attorney maintains an office and the court would determine a reasonable fee for such services. Senator McClellan introduced this bill "to correct what I consider to be inequities in the allowance of attorney fees in proceedings before certain administrative agencies. Many of the existing limitations * * * are a direct outgrowth of the depression years. The maximum amount now allowable reflects the general attitude of the time." The Senate Judiciary Committee felt that restrictions on fees interfered with the Lawyer-Client relationship, and that they discouraged attorneys from representing such claimants. Even if counsel could be obtained it was felt that his services would be of very poor quality. Although S. 1522 passed the Senate and was sent to the House Judiciary Committee, it was not acted on by the House Committee. The American Bar Association supported this bill, but did not actively work for its passage.

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[1] Prepared by Ms. Christi White, Technical Information Specialist, Congressional Research Service.

FEES BEFORE THE COURTS

The year previous to the passage of the McClellan bill, the Congress had passed the Social Security Amendments of 1965 which, in sec. 332, instituted a statutory limitation on the fees that a lawyer could charge for services rendered before a court on a Social Security case. The law provided that when a court handed down a judgment favorable to a claimant in a case involving Social Security claims the judge was to determine a reasonable fee, not to exceed 25 percent of the claimant's past-due benefits.

Previous law, while giving the Secretary of HEW the authority to set fees for representation before the agency, had been silent as to the regulation of attorney fees in court proceedings. The 1965 provision to limit attorney fees originated as an Administration proposal, whose spokesman argued that most fee arrangements in such cases were of the contingency type and that the percentages of the benefits the lawyer could receive as a fee were frequently as high as 33 to 50 percent of the accrued benefits. Because there often was a considerable lapse of time resulting from litigation, some attorneys were able to collect an inordinately large fee. Thus, in their view, this limitation on fees was necessary to protect the claimant. The House bill had no similar provision. In conference the Senate version of H.R. 6675 as it pertained to attorneys' fees was accepted by the House.

Although the 1965 law allowed a maximum of 25 percent of the claimant's total past-due benefits in Court cases the Supreme Court ruled in *Hopkins* v. *Cohen*, 390 U.S. 350 (1968), that the maximum fee allowed could be 25 percent of the past-due benefits of the claimant and all his dependents. The petitioner argued that low fees would discourage attorneys from taking such cases and this would ultimately hurt the claimant. The Government argued that the wording of the law was clear. "Claimant" in this section meant only the claimant as it does in all other sections. The government brief went on to state that:

> It is notable that Congress, in this unambiguous statute, did not provide that attorneys' fees may rest on past amounts due dependents who do not and need not litigate their derivative claims. Congress could hardly have intended to provide a larger fee for the married claimant who receives the same legal services as the single claimant (p. 7).

The Seventh Circuit Court of Appeals in affirming the lower court order to award the attorney of Mr. Hopkins 25 percent of his benefit alone stated that:

> We think it unlikely that Congress intended that in a case like this the maximum fee should be more than twice as large as it would have been if Mr. Hopkins happened to be single.

The Supreme Court rejected these arguments, however, no data as to attorney's fees awarded in Social Security cases before the courts is presently available to indicate whether any preference is being given to claimants with family benefits as contrasted with single workers.

FEES AT ADMINISTRATIVE LEVEL

About a year and a half after the Senate passed the McClellan bill, it considered a floor amendment to the 1967 Social Security Amendment introduced by Senator Ervin. Some attorneys had complained that claimants did not pay them after benefits had been awarded. This provision enabled the Secretary to pay the lawyer directly. As in previous laws the Secretary of HEW retained the authority to fix a fee for services rendered before him. But this new provision stated that in proceedings which are decided in favor of the claimant the Secretary may certify for payment directly to an attorney the smaller of (a) 25 percent of the past-due benefits, (b) the fee fixed by the Secretary or (c) the amount agreed to by the applicant and the attorney.

As it stands now by regulation a lawyer must file a petition to have his fee approved, regardless of the amount. The regulation exempting fees below 30 dollars was eliminated. For services rendered below the hearing level an attorney must petition the Bureau of Disability Insurance for approval. Such services would include not only conferences with the claimant but also the gathering of evidence such as additional medical examinations work history, etc. Usually 25 percent of the first check is withheld to allow for the payment of the attorney.

In 1973, 1,438 petitions were received, the total amount requested was $556,656.85 and the total amount approved was $431,572.02. The average fee requested was $387.10 and the average fee approved was $300.12. In 72.9 percent of the cases, the fee was approved in the amount requested by the representative.

For appeals which reach the hearing level the attorney must file a petition with the Administrative Law Judge who heard the case. If the fee requested is more than $1,500, the request is considered by the central office of the Bureau of Hearings and Appeals. The limit for ALJ consideration was changed from $500 to $1,000 in 1971, and to $1,500 in May 1974. The average fee awarded in fiscal 1973 was $600. The average fee requested was $706. There were 6,956 petitions and the total amount of authorized fees was $177,000. Lawyers represented disability claimants in 35 percent of the cases decided by the BHA in FY 1973. This was a 3 percent increase from the FY 1972 figure.

BLACK LUNG

Fee setting in "Black Lung" cases poses a much more controversial issue. Here the criticism has been not too low fees but too high fees. For Federal "Black Lung" disability benefits the fees were unregulated by statutes until 1972 when the provisions for setting fees in Social Security Disability cases, at both the administrative and court level, were made applicable to Federal Black Lung cases by the 1972 Black Lung amendments. By regulation this fee setting was made applicable to cases for which a decision had not been reached by the effective date of the 1972 provision even if substantially all the work by the attorney had been performed prior to the passage of the law. This regulation is similar in retroactivity to the Social Security regulation which certified the payment of a maximum of 25 percent of past due benefits for court cases filed for Social Security benefits applicable to all cases where a decision had not been reached.

A decision was recently handed down in the Eastern District of Kentucky (*Watson* v. *Weinberger*, Civil No. 2185) which may have repercussions for the Social Security program as well as the Black Lung program. Although the regulations governing attorney fees for Black Lung cases were declared valid, the regulation which applied the limitation to all cases undecided at the effective date of the 1972 legislation was declared void, and the attorney who brought the suit was awarded the fee stipulated in the contract with his client. A motion by the Secretary to reconsider the decision has been turned down and the government is considering appealing the case If upheld there may be considerable litigation from attorneys for Social Security claimants and Black Lung claimants whose contracts for fees have been declared void by HEW.

The main problem concerning Black Lung legal fees arises out of the relationship of the Black Lung program to the State workmen's compensation program. Under Federal law a claimant who files a claim before December 31, 1973, must have filed a State workmen's compensation claim. Various States have different laws for workmen's compensation (see Appendix A). In general the administration or court which awards the claim sets the attorney's fee. Some States such as Tennessee and Kentucky have maximum percents of award limitation on fees while others such as Pennsylvania have no such provision. Under the Black Lung program if a workman is awarded a benefit the attorney fee granted is paid by the claimant out of his benefits. If the claimant is then also awarded a benefit under the Federal Black Lung program (which usually occurs) the amount of the miner's Federal Black Lung benefit will be reduced by the amount of money he actually receives from the State workmen's compensation program, (his award minus his legal and other exptnses incurred in pursuing his State claim). The effect of this system is to guarantee to the claimant an amount of combined State and Federal Black Lung compensation at the Federal level of compensation. However, the attorney fee allowed in connection with litigation of a Federal Black Lung claim is deducted from the Federal award, but the attorney fee or the State award is, in a sense, subsidized because it is not taken into account in the deduction mechanism. This mechanism was devised in part to prevent penalizing the applicant who applied for the Federal program in a State which had a workmen's program which allowed claims in Black Lung cases, since in order to receive his Federal benefit he must have applied for that State's workmen compensation benefit.

The Comptroller General recently finished a study requested by Congressman John N. Erlenborn.[2] The report stated that four attorneys in Kentucky have collected $5,088,090 in 1,225 Black Lung cases in fiscal years 1971–73. These attorneys were awarded the maximum fee in 93.3 percent of the cases with an average fee of $4,154 per case. The GAO made some computations based on the Manual of the Kentucky State Bar Association and stated that "the hourly rate of these attorneys ranged from $155 to $238." In contrast the average Black Lung fee awarded by the Social Security Administration for fiscal 1973 was $419 per case. This is lower than the average fee for regular Social Security Disability cases.

This study points up some of the problems of attorney fees under Part B of the Black Lung program. There are also several attorney fee problems under Part C which is now being administered by the Department of Labor but this is beyond the scope of this report.

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[2] "Information on Attorneys Fees Paid for State Black Lung Workmen's Compensation Claims in Kentucky," Jan. 8, 1974. See app. B.

APPENDIX A

TABLE 114.—*Workmen's compensation programs for selected coal mining States (Jan. 1, 1973)*

Jurisdiction	Administration	How Claims are Settled	Review by Agency	Modifications	Court Appeals	Attorney Fees
Kentucky	Workmen's Compensation Board in Department of Labor.	By agreement subject to approval of Board. Disputed cases determined by Appeal Board after hearing. Claim may be assigned to referee for hearing.	By Board within 14 days from decision of member or hearing officer.	By Board at any time, on application or own motion.	To Circuit Court within 20 days; further appeal to Court of Appeals if amount involved is sufficient.	Maximum of 20 percent of amount recovered.
Pennsylvania	Department of Labor and Industry.	By agreement, after 7 days from injury, subject to approval of Department. Disputed cases determined by Appeal Board after hearing. Claim may be assigned to referee for hearing.	By Appeal Board from referee's decision within 20 days.	By Department on application within 2 years.	To Commonwealth Court within 20 days; Further appeal to Supreme Court within 30 days.	Subject to approval of referee, Appeal Board or Court.
Tennessee	Courts and Department of Labor.	By agreement, subject to approval of Circuit Court. Disputed cases determined by County Court.	No provision	By Court, on application after 6 months. Award payable for more than 6 months may be approved by Court.	To Circuit Court within 10 days; further appeal to Supreme Court.	Subject to approval of Court; limit 20 percent of recovery or award.
Virginia	Industrial Commission.	By agreement, after 10 days from injury, or at anytime after death, subject to approval of Commission. Disputed cases settled by Commission or member thereof after hearing upon application.	By full Commission within 15 days after opinion.	By Commissioner on own motion or application at any time.	To Supreme Court within 30 days.	Subject to approval of Commission.
West Virginia	Workmen's Compensation Commissioner.	Commissioner; hearing upon application.	By Appeal Board within 30 days.	By Commissioner within set time limits, on written application; subject to review by Appeal Board.	To Supreme Court of Appeals within 30 days.	Maximum fees established. Limited to 25 percent of total award. Not to exceed $500.

APPENDIX B

Comptroller General: Information on Attorney Fees Paid for State Black Lung Workmen's Compensation Claims in Kentucky, January 8, 1974, No. B-164031(4)

REASONABLENESS OF ATTORNEY FEES IN KENTUCKY

The four attorneys were either unwilling or unable to tell us the amount of work involved in representing the claimants and we could not determine the criteria the board used in authorizing the fees. Therefore, although we were unable to obtain all the information we desired, the information which we were able to document presented a prima facie case, in our opinion, that the fees authorized by the board in most cases we reviewed were excessive.

This information revealed that—

the board authorized the maximum fee of 20 percent of the awards in about 90 percent of the cases, regardless of the services provided by the attorneys;

the average fee in fiscal year 1973 was $4,277 for each award, compared to the average attorney's fee of $419 SSA authorized for Federal black lung cases;

the computed average billing rate for the four attorneys during fiscal year 1973 was $215 an hour;

maximum fees were authorized in a number of cases that we believe were relatively easy to adjudicate;

a private study for the Kentucky Commissioner of Labor concluded that the fees were excessive; and

a black lung task force formed by Kentucky recommended reducing the fees.

REGULATION OF ATTORNEY FEES IN KENTUCKY

Kentucky workmen's compensation claims are adjudicated under an adversary system which requires that the claimant prove his eligibility for benefits in a quasi-judicial procedure. Such a system, in effect, requires the claimant to retain the services of an attorney.

Kentucky's regulation of attorney fees in State black lung workmen's compensation cases is governed by section 342.320 of the Kentucky Revised Statutes. All attorney fees paid under the workmen's compensation laws must be approved by the Workmen's Compensation Board. The board consists of five members appointed by the Governor each for a term of 4 years. The members of the board must have the qualifications of a circuit court judge.

The maximum allowable attorney fee in Kentucky is 20 percent of the value of the award under the State's Workmen's Compensation Act. The board has the authority to allow less than the maximum permissible attorney fee even though the attorney and the claimant have agreed to the maximum amount. In each case the board is required to examine the record to ascertain the extent of services rendered and to fix a reasonable fee for such services. According to Kentucky statutes, the board, in determining the reasonableness of attorney fees, should consider the time and effort required to present and prosecute the claim and the results achieved.

Records of the Kentucky Department of Labor showed that the board authorized attorney fees totaling $5,277,792 during fiscal year 1973 for 1,234 cases, or an average fee of $4,277. The board authorized the maximum attorney fees in 1,118, or 91 percent of the cases. In 1973 the board dismissed 184 cases, for which the attorneys received no fees. Thus, of the 1,418 cases considered by the board, 1,234, or 87 percent, resulted in awards for which fees were authorized.

The board seems to have been more conservative in authorizing maximum fees in fiscal year 1974. In July and August 1973, the board authorized the maximum fee in 127, or 72 percent of 177 cases. The average authorized fee during these 2 months was $4,020.

ANALYSIS OF FEES PAID TO FOUR ATTORNEYS

The four attorneys received $2,317,450, or 44 percent of the $5,277,792 in fees authorized, in fiscal year 1973.

These four attorneys were authorized fees totaling $5,088,090 for 1,225 cases in fiscal years 1971–73. The board authorized the maximum attorney fee in 93 percent of the cases.

Attorney and fiscal year	Total fees	Number of awards	Awards when maximum fee was authorized	Percent of awards when maximum fee was authorized	Average fee
A:					
1973	$1, 142, 718	259	247	95. 4	$4, 412
1972	886, 714	214	208	97. 2	4, 144
1971	111, 928	28	27	96. 4	3, 997
Subtotal	2, 141, 360	501	482	96. 2	4, 274
B:					
1973	454, 528	101	95	94. 1	4, 500
1972	487, 996	119	108	90. 8	4, 101
1971	328, 759	88	78	88. 6	3, 736
Subtotal	1, 271, 283	308	281	91. 2	4, 128
C:					
1973	186, 315	44	42	95. 5	4, 234
1972	104. 477	26	24	92. 3	4, 018
1971	16, 093	4	4	100. 0	4, 023
Subtotal	306, 885	74	70	94. 6	4, 147
D:					
1973	533, 889	135	116	85. 9	3, 955
1972	600, 028	144	133	92. 4	4, 167
1971	234, 645	63	61	96. 8	3, 725
Subtotal	1, 368, 562	342	310	90. 6	4, 002
Total	5, 088, 090	1, 225	1, 143	93. 3	4. 154

ESTIMATED HOURLY BILLING RATE

We met with the Kentucky Workmen's Compensation Board to ascertain the criterion used for authorizing attorney fees in the State black lung workmen's compensation cases. Board officials said that they had no written criteria to follow in setting attorney fees and that the only criterion they used was their judgment as lawyers. Further, our discussions with these attorneys gave us little insight as to the amount of time and expenses involved in presenting State black lung claims. We computed an estimated hourly billing rate on the basis of the fiscal year 1973 payments to the four attorneys and the annual billable hours shown in the May 1971 Fee Manual of the Kentucky State Bar Association. This manual states:

> Every attorney, regardless of his competence and station, operates under an inescapable restriction—the matter of available time. Billable time is invariably still less. Assuming perhaps rather generously, 1200 billable hours in a year (i.e., 5 billable hours, every day, 240 office days per year), and assuming that each of the 1200 hours is fully billable at $25.00 annual billings will be $30,000.00.

Using this method, we estimated that the hourly rate for these attorneys ranged from $155 to $238.

Attorney	Number of attorneys on staff	Annual billable hours per Kentucky fee manual	Total billable hours	Total black lung fees 1973 (thousands)	Estimated hourly billing rate
A	4	1, 200	4, 800	$1, 142. 7	$238
B	2	1, 200	2, 400	454. 5	189
C	1	1, 200	1, 200	186. 3	155
D	2	1, 200	2, 400	533. 9	222
Total	9		10, 800	2, 317. 4	215

Although these computations produce an average hourly billing rate of $215, we noted that the Kentucky Bar Association Fee Manual recommends a contingent fee of 33⅓ percent of the amount recovered as compared with the maximum fee of 20 percent in the statutes for workmen's compensation claims. Even though fees paid on workmen's compensation claims (at a maximum 20 percent) are contingent on the outcome of the case, the award rate on black lung claims in Kentucky during fiscal year 1973 was 87 percent, as discussed on page 4, which indicates a rather low risk during that year.

Kentucky Governor Wendell H. Ford formed a 14-member black lung task force to analyze, among other things, the attorney fee situation and to recommend improvements. The 14-member force included attorneys and representatives from the UMW, coal operators, Kentucky General Assembly, Workmen's Compensation Board, and the Kentucky Department of Labor. On July 5, 1973, the Black Lung Task Force recommended in its report that Kentucky—

revise its legislation to provide a maximum attorney fee of $750 in a noncontested claim;

establish a maximum fee of $4,212, unless the attorney can justify a higher fee; and

require any attorney representing a claimant for black lung benefits to support a claim for a fee by a detailed affidavit including a statement of the number of hours he spent in prosecution of the claim.

As a result of this report, the Workmen's Compensation Board revised its regulations, effective July 14, 1973, to require a detailed statement in affidavit form of the amount of work done, time spent, complexity of issues involved, and any related materials the attorney used in making the request. Although, as noted on page 4, we compiled data on fees authorized by the board during July and August 1973, none of these fees were applicable to cases filed under the July 14, 1973, regulations. The board is not expected to act on the first two recommendations until the Kentucky General Assembly convenes in January 1974, because State officials feel that implementing the first two recommendations will require amendments to Kentucky statutes.

ATTORNEY FEES AUTHORIZED IN BLACK LUNG CASES BY THE SOCIAL SECURITY ADMINISTRATION

SSA officials told us that the attorney fee in a Federal claim is authorized on the basis of the value of his services to the claimant and in an amount that will reasonably compensate the attorney. Neither a fee agreement nor an hourly rate is included in the criterion used in determining a reasonable fee. The maximum attorney fee in a Federal claim is 25 percent of the claimant's past-due benefits rather than the value of the total award. According to SSA, attorneys were authorized a total of $854,000 for 2,036 cases by SSA's Bureau of Disability Insurance from November 1972 through May 1973 and by SSA's Bureau of Hearings and Appeals from September 1972 through May 1973. The average attorney fee for these cases was approximately $419. According to Kentucky officials and certain attorneys we interviewed, a Kentucky black lung workmen's compensation claim generally requires more effort by an attorney than does a Federal black lung claim.

ATTORNEY FEES FOR BLACK LUNG WORKMEN'S COMPENSATION CLAIMS IN OTHER STATES

As in Kentucky, the regulation of attorney fees in State black lung workmen's compensation claims in Pennsylvania, Virginia, and West Virginia is governed by the statutes. The attorney fees authorized in State black lung workmen's compensation cases are insignificant compared with the fees paid attorneys in Kentucky because (1) UMW attorneys represent a large number of claimants in these States but less than 1 percent of the claimants in Kentucky and (2) claimants do not always have to retain attorneys to obtain benefits.

PENNSYLVANIA

As of July 1, 1973, employees and their dependents can apply for lifetime benefits for occupational diseases, such as black lung, under either the Occupational Disease Act or the Workmen's Compensation Act. Each act has different provisions governing the payment of attorney fees. The Occupational Disease Act requires that attorney fees be approved by the Workmen's Compensation Board but sets no statutory limit on them. The Workmen's Compensation Act, effective July 1, 1973, does not authorize the Department of Industry and Labor or the Workmen's Compensation Appeal Board to reduce agreed-upon attorney fees which are 20 percent or less of the amount awarded. These State authorities' allowing attorneys fee in excess of 20 percent is discretionary.

According to a Pennsylvania official, attorneys of claimants under the Occupational Disease Act generally charge about $300 for their services. This official said that a large percentage of claimants in Pennsylvania are represented by UMW attorneys at no cost to the claimants. A Pennsylvania official told us that about 90 percent of the miners in Pennsylvania were UMW members and were therefore eligible for the free services of UMW attorneys.

At the time our fieldwork was completed in Pennsylvania, no fee had been approved under the Workmen's Compensation Act, as amended July 1, 1973.

VIRGINIA

The Industrial Commission approves and awards attorney fees; no maximum fee is set out in the statutes. The matter is left to the discretion of the Industrial Commission. A State official said that 97 percent of all applicants for State black lung benefits in Virginia were represented by UMW attorneys at no cost to the claimants. A State official told us that, in those few cases where private attorneys are retained, the fees are generally 15 percent of the claimants' awards. During calendar year 1972, Virginia made 237 awards totaling $720,840 to claimants for State black lung benefits. On the basis of information furnished to us by a State official, it appears that private attorneys were involved in only seven cases in calendar year 1972. The fees for these cases may have totaled about $3,200.

WEST VIRGINIA

Attorney fees in West Virginia State black lung claims cannot exceed 25 percent of the benefits to be paid during 208 weeks. The West Virginia Workmen's Compensation Board is given no power to allow or approve attorney fees or to enforce the fee limitation.

State officials said that applicants for State black lung workmen's compensation were not required to retain attorneys to obtain benefits. State and UMW officials also said that many claimants were represented by UMW attorneys. On the basis of our discussions with West Virginia and UMW officials, we estimate that private attorneys represented claimants on about 10 percent of the awards during fiscal year 1972. The fees in these cases may have totaled about $300,000.

As agreed with your office we are sending copies of this report to Senator Robert J. Dole and to the Chairman, Subcommittee on Labor, Senate Committee on Labor and Public Welfare. We do not plan to distribute this report further unless you agree or publicly announce its contents.

Sincerely yours,

ELMER B. STAATS,
Comptroller General of the United States.

13. GAO Study of Disability Denials

Staff question to GAO: ***We understand that you are making a study of denied disability applicants who do not request a reconsideration of their benefits. Please describe this study and progress to date.***

STATEMENT OF GAO WORK ON THE SOCIAL SECURITY DISABILITY PROGRAM

One of every two applicants for Social Security disability benefits is denied them. Of those denied, about 40 percent request that SSA reconsider their case, about half of which are eventually awarded benefits during the appeals process. Little is known about the remaining 60 percent of the original denials, or those who remain denied after the appeals process is completed. These represent about 40 percent of all applicants (1.1 million in 1973) for disability benefits.

Our current review in the Social Security disability area features an analysis of a statistical sample of individuals who were denied disability benefits from 1967 through 1971 to determine what has happened to them. Our work resulted in part from a 1970 Johns Hopkins University report to the Social Security Administration (SSA) containing a recommendation that certain persons who are denied disability benefits should be systematically recalled and reassessed to evaluate probable changes in their disability status and thus possible changes in their eligibility for disability benefits. The recommendation was based on study findings which showed that about 24 percent of those in the study who were denied disability benefits from 1 to 4 years earlier were assessed by SSA as eligible for disability benefits—the reported implication being that these applicants had become more disabled than before, or other compensating factors entered into the reassessment, or both. These findings appear significant in light of the approximately 2.1 million persons who were denied disability benefits for medical reasons from 1967 through fiscal year 1973.

SSA has formally advised us that it is not convinced that systematically reevaluating the conditions of certain denied applicants would be feasible or desirable. In this regard, SSA has taken and plans to take no action as a result of the findings and recommendations in the Johns Hopkins report. SSA advised us further that—based to a large extent on the premise that denied persons themselves are in the best position to later reassess their own health condition—its policy is to (1) inform denied claimants of program requirements, reasons they do not meet these requirements, and their right to appeal, and (2) rely on the claimants to decide whether to re-file.

We took a statistical sample (890 cases) of the approximately 1.2 million individuals who were denied Social Security disability benefits for medical reasons during the five calendar years from 1967 thru 1971. Questionnaires (designed jointly by GAO and SSA) were developed to determine primarily if (1) their medical condition has worsened, (2) they understand that they have the right to file a new disability claim, (3) they are presently working, and if so what were their earnings during the past 12 months, and (4) they would like to file a new application for disability benefits if they feel they are disabled.

We did not send questionnaires to 93 individuals including 22 deceased, 29 who were receiving benefits at the start of our review, 22 who had lost their eligibility for benefits due to a lack of the required Social Security quarters of coverage, and 20 who had disability claims pending at the start of our review. In addition, we have been unable to locate 88 individuals, and to date have received no reply from 78 others. Consequently, we have received questionnaires from 631 or 71 percent of our original 890 sample cases to date. We have turned over the 631 cases to SSA to contact all of those individuals who could possibly be eligible for benefits, and to secure a new application from them if possible.

SSA screened out 140 individuals before making contact with them because (1) they earned too much, (2) they have been employed for over 12 months, and (3) they stated on their questionnaire that they do not wish to file a new application for disability benefits. Therefore, SSA is to contact 491 individuals.

Of the approximately 400 individuals contacted by SSA to date, about 200 declined to file new applications either because they no longer considered themselves to be disabled or because they indicated dissatisfaction with the Social Security system for any of numerous reasons. SSA has notified us of 204 applications filed by sample individuals since the start of our study, and as of March 20, 1974, there have been 109 final adjudications, including 9 awards and 100 denials.

Regarding the recommendations contained in the Johns Hopkins report, we have spoken to several prominent physicians in Baltimore and New York. Most of these physicians advised us that the program would be workable and desirable for large numbers of disabled people. Most of them seemed quite certain that such a program would be operable by State Agency physicians and that it would be a valuable aid to the disabled population.

Aside from the desirability and feasibility of the recall and reassessment program, there are several notable areas of concern that have surfaced as a result of our review work to date.

1. About 30 percent of the people who responded to our questionnaire stated that they did not know or understand that they could refile an application for benefits if their medical condition worsened or if they developed a new one.

2. About 60 people, or 10 percent, of those who responded to our questionnaire complained of the misinformation and mistreatment they received when dealing with Social Security District Office personnel. Most complaints centered around a feeling of degradation and insult as a result of their application interview.

3. Many people denied Social Security disability benefits are earning little or no income. About 50 percent of the people in our sample were earning $1,680 a year or less, which is the present maximum allowable earnings for eligibility under the disability program; about 10 percent were earning more than $1,680 but less than $2,400 a year, which is the present amount used for the retirement test by the Social Security retirement and survivors insurance program. This may indicate a gap between a substantial wage and the existing earnings criteria for eligibility for disability benefits. The remaining 40 percent of the people in our sample were earning over $2,400 a year.

14. Railroad Retirement Disability Program [1]

The U.S. Railroad Retirement Board has administered a program of disability benefits dating back to the original Railroad Retirement Act of 1935. More than 300,000 employee disability annuities have been awarded, slightly more than 100,000 of which are still in current-payment status. This article reviews the program's legislative developments over the years, principal provisions, administrative procedures of the Board, coordinating provisions with other programs, and selected statistical data, arising from operations of the program. Effects of the Medicare program for disabled railroad retirement beneficiaries are beyond the scope of the article.

LEGISLATIVE HISTORY OF DISABILITY PROGRAM

The disability provisions of the Railroad Retirement Act have undergone a number of changes since the original legislation of the 1935 Act. In addition, the Board's program has been affected by the various amendments to the social security program since the disability freeze provisions were first added to that program in 1954.

The original 1935 railroad retirement program provided disability annuities at ages under 65 to employees who had 30 or more years of service. The 1937 Act liberalized the service requirements at the older ages but defined disability more strictly. Annuities were made available at ages 60–64 on an actuarially reduced basis to employees with less than 30 years of service but disability was defined as total and permanent disability for all regular employment. The 1935 Act had implicitly permitted retirement on occupational disability.

The 1946 railroad retirement amendments made additional important changes of significance by providing annuities based on occupational disability, reducing the service requirement for total disability retirement before age 60 from 30 years to 10 years, and eliminating the actuarial reduction for disability annuities. The current connection provision for occupational disability annuities was also added at this time. A current connection exists at an annuity beginning date if the employee worked in the railroad industry in at least 12 out of the last 30 calendar months before the month in which his annuity begins, or out of an earlier 30-month period if he had no regular nonrailroad employment (other than self-employment) after that period.

The 1951 amendments introduced the current basic 10-year service requirement for eligibility for all railroad retirement annuities, thus eliminating as an eligible category those disabled employees aged 60–64 who had less than 10 years of service. Aside from periodic changes in the annuity computation formula, there has been no direct railroad retirement legislation subsequent to 1951 which has affected the general structure of the railroad retirement disability program for employee annuities, although annuities for surviving disabled children were introduced in 1954 and for disabled widows in 1968.

However, the railroad program has been affected by several amendments to the Social Security Act, the most important of which accomplished the following:

1. Periods of disability could be eliminated in computing the average monthly wage—effective July 1955 (the original disability freeze provisions).
2. Social security benefits became payable to permanently and totally disabled employees age 50 and over—effective July 1957.
3. Monthly benefits were payable to qualified wives and minor or disabled children of disabled social security beneficiaries—effective September 1958.
4. Age 50 restriction on receipt of social security disability benefits was eliminated—effective November 1960.

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[1] From the RRB Quarterly Review, January–March 1974.

5. Effective September 1965, disability definition was liberalized to cover any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, and must be based on inability to engage in any substantial gainful activity. Prior to this time, benefits were payable only if the impairment could be expected to be of long-continued and indefinite duration or to result in death.

6. The 1967 social security amendments made the disability definition more restrictive by specifying that the applicant must not only be unable to do his previous work or work commensurate with his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy. This is true regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

7. Waiting period for disability benefits was reduced from six months to five months—effective January 1973.

These amendments affect railroad retirement beneficiaries through the social security guaranty.

Amendments in 1958 to both the Railroad Retirement and Social Security Acts gave the Board authority to make disability freeze determinations for railroad employees with 10 or more years of service.

As of July 1, 1973, Medicare coverage before age 65 was made available for disabled employee annuitants, disabled widows on the rolls who are at least age 50, and disabled children (of retired or deceased employees) over age 18 if they were disabled before age 22.

DISABILITY ANNUITY PROVISIONS

The disability program has been confined primarily to employee annuities, with the exception of limited activity in the survivor area for disabled children and disabled widows. Two types of employee disability annuities are available to qualified applicants, each providing the same benefits and being subject to many of the eligibility requirements for nondisability annuities:

1. *Total disability.*—Eligibility based on total disability requires 10 years (120 months) of railroad service and a physical or mental condition which has permanently disabled the employee for all regular, gainful employment as defined by the Board's standards. An employee qualifies as totally disabled if his condition can be expected to last at least one year or to result in death, and is such that he is unable to perform regularly in the usual and customary manner the duties of any regular gainful employment (railroad or nonrailroad) which is substantial and not trifling.

2. *Occupational disability.*—Eligibility for an occupational disability annuity is based on the completion of 10 years of railroad service if the employee has reached age 60, or 20 years if he is under age 60. His physical or mental condition must be such as to disqualify him permanently for work in his regular railroad occupation. In addition, he must possess a current connection with the railroad industry at the time his annuity begins.

Both types of employee disability annuities are payable from the date of disability onset and not subject to waiting periods such as are present in the social security program and in the disability contracts of most private insurance carriers.

Annuities for disabled children entered the system in the 1954 railroad retirement amendments which expanded the already existing program of children's annuities by adding survivor benefits for dependent disabled children age 18 and older whose disabilities began before age 18. The 1973 railroad retirement "conforming" amendments extended disabled children coverage to disabling conditions beginning before age 22.

The 1968 railroad retirement amendments introduced benefits for totally and permanently disabled widows starting as early as age 50. For eligibility purposes, a widow's disability must begin no later than seven years after the employee's death or seven years after she ceases to be entitled to widowed mother's benefits as a result of no longer having an eligible surviving child in her care. Comparable benefits had been added earlier to the social security program but with a more stringent definition of total and permanent disability than for employee disabilities. Railroad retirement law follows the social security employee definition for both employees and widows.

Benefit formulas

Amounts of employee disability annuities payable under the railroad retirement program generally follow the same pattern as that found in the social security system and in private pension plans, namely, a benefit computed in accordance with the formula for employee nondisability annuities but not subject to actuarial or other reductions for receipt of the benefit prior to the age at which unreduced annuities are available. During the 1937–46 period, railroad retirement employee disability annuities were subject to actuarial reduction but the 1946 amendments to the Railroad Retirement Act removed this restriction and the present format has been in effect since then.

A variation of the above format exists in a minor proportion of disability annuities because of the special social security minimum guaranty. Under this special guaranty, regular railroad retirement benefits to a retired employee and his family cannot be less than 110 percent of the amount the family would have received under the Social Security Act if railroad earnings had been credited under that Act, less any benefits for which family members are actually eligible under the social security system. Because only totally disabled employees are eligible for benefits under the Social Security Act, this guaranty does not cover employees disabled only for their regular railroad occupations. Therefore, all cases involving disabled annuitants are examined to see whether they could have qualified for benefits under the social security provisions.

As far as disability retirement annuities are concerned, the guaranty provision is of value chiefly to totally disabled employees under age 65 who have minor children. The guaranty seldom applies to railroad employees with long service because the standard formula ordinarily produces a much higher annuity. Neither does it apply in the great majority of cases in which the railroad retirement annuitant is simultaneously entitled to a social security benefit based on nonrailroad earnings since the full amount must be deducted in computing the guaranty amount but not in computing the annuity under the regular railroad formula.

There is also a special railroad minimum formula which may be applicable instead of the standard formula in a small number of cases with short service. A current connection with the railroad industry at retirement is required in such cases.

Work restrictions

Employee disability annuitants are subject to the general work restrictions imposed by the Railroad Retirement Act. No annuity is payable for a month in which the annuitant works for a railroad employer or for his last nonrailroad employer. In addition, a disability annuity is not payable to an employee under age 65 for any month in which he earns more than $200, even in employment which would otherwise be permissible. However, at the end of each calendar year, the amounts withheld are restored if the earnings in the year are less than $2,500. If the annuitant earns $2,500 or more in the year, he loses one month's annuity for each $200 in excess of $2,400, counting the last $100 or more as $200. No deductions are made for any month in which the annuitant earns $200 or less and the special restriction ceases entirely when the disability annuitant attains age 65.

Disabled widows and disabled children receiving annuities are restricted from railroad employment and are subject to the social security earnings limitations, currently starting at $2,400 per year with a $1 benefit reduction for each $2 of additional earnings so long as the annuitant is under age 72.

ADMINISTRATIVE PROCEDURES

Disability evaluations

Disability determinations are made by Board personnel with specialized training in the field. Aside from certain presumptive disabilities, decisions are based on an objective analysis of each case. In decisions on occupational disability, the Board is assisted by standards developed in cooperation with representatives of railroad employers and employees.

Medical evidence forming the basis of decisions comes from the physicians of the applicant and his employer. In a substantial number of cases, additional evidence is supplied by medical examiners designated by the Board. Nonmedical factors such as the age, education and work experience of the applicant are considered along with the medical evidence in evaluating the disability application.

Appeals procedure

Whenever a person claiming benefits under the Railroad Retirement Act has his application denied, or is dissatisfied with the award, he may appeal for reconsideration up to one year after the date of notice of the initial determination.

If the operating bureau reconfirms its original decision, the case is forwarded to the Office of Hearings and Appeals which is the highest authority below the Board members in considering and making determinations on appeals under the Railroad Retirement Act. The appellant may, as an optional part of the appeals procedure, request an oral hearing to which he may be accompanied by his legal counsel, union representative, or any other individual he feels might be helpful to him in presenting information about his claim.

Following the hearing, the entire record, including possibly a medical examination at the Board's medical facility and the transcript of an oral hearing, is referred to a Board medical consultant for an opinion of the appellant's eligibility for disability benefits or for the establishment of a disability freeze period. If an appellant is dissatisfied with the decision rendered, he has recourse to further appeals, first with the Board itself within four months from the date that notice of the decision was forwarded to him, and finally with a U.S. Circuit Court of Appeals within one year after notice of the Board's decision. About 20 percent of the initial determinations denying disability annuity applications in recent years have been reversed in appeals proceedings.

COORDINATION WITH OTHER PROGRAMS

Sickness benefits program of RUIA

Most railroad disability annuitants, because of their disabling conditions, receive sickness benefits under the RUIA either before the disability annuity begins or during the early months that the annuity is payable. The employee is allowed to specify when he wants his disability annuity to begin and many elect to have the beginning date subsequent to the expiration of their eligibility for sickness benefits.

If an employee meets the eligibility requirements under both programs, he may receive sickness benefits only to the extent that they exceed the amount of the disability annuity for the same period. Under current law, the monthly maximum amount payable as a sickness benefit ($279.40 based on 22 compensable days per month at a maximum daily rate of $12.70) may exceed the amount which would be payable as a disability annuity since the size of this latter amount under the railroad retirement employee annuity formula is heavily dependent upon the years of credited railroad service entering into the computation.

Coordination with social security program

The railroad retirement and social security systems are coordinated in a number of ways, including a financial interchange between trust funds, the special-guaranty provision, and their earnings base and tax rates. Insofar as the railroad retirement disability program is concerned, the most important area of coordination is in making disability freeze (periods of disability) determinations within the meaning of the Social Security Act for railroad employees with 10 or more years of service. This is needed to determine if (1) the case will be included in the financial interchange calculations, (2) the benefit can be computed under the social security guaranty, and (3) survivor benefits payable after the employee dies (when these are payable under the social security minimum guaranty) can be increased.

STATISTICAL DATA

Disability determinations

The number of disability determinations under the railroad retirement program has varied widely over the years, ranging from a low of 2,300 in the initial year to a peak of 23,400 in 1947–48. Table 115 shows two distinct cycles in disability determination activity followed by relative stability during the last two decades. As would be expected, the number of determinations rose sharply in the early years as the system became accepted and gradually absorbed the backlog of employees who were totally disabled when the system was established. Following a leveling-off period which included World War II, the number of determinations mushroomed in the immediate post-World War II years, primarily because of liberalizations in the disability provisions and the introduction of employee annuities based on occupational disability. In later years, relative stability has prevailed, existing levels reflecting industry employment changes primarily.

Percentage figures relating to claims allowed have fluctuated in a rather narrow range, reaching and exceeding 90 percent in two periods—the last few years of the 40's and the most recent period beginning with 1966. Since these two time periods directly follow major liberalizations in disability provisions, the 1946 railroad retirement amendments in one instance and the 1965 liberalization of the social security disability definition in the other, it can be inferred that the higher ratios of initial claims allowed are a direct result of the liberalizations and might be expected to continue at present high levels in the foreseeable future.

Financial and census characteristics of disability annuity awards

Table 116 provides selected information on disability annuity awards since the beginning of the program, including data on annuities being paid at the end of each year to individuals still under age 65 at that time.

TABLE 115.—*Initial employee claims for disability*[1] *allowed and disallowed by year, 1937–72*

[Figures rounded to nearest hundred]

Year[2]	Number of claims		Percent allowed
	Total	Allowed	
1936–37	2, 300	2, 000	88
1937–38	5, 900	5, 200	89
1938–39	11, 700	9, 600	82
1939–40	7, 000	5, 900	84
1940–41	6, 400	5, 300	83
1941–42	5, 000	4, 000	80
1942–43	4, 800	4, 000	84
1943–44	5, 300	4, 200	80
1944–45	5, 400	4, 300	80
1945–46	6, 200	4, 900	79
1946–47	10, 000	8, 000	80
1947–48	23, 400	21, 100	90
1948–49	15, 000	13, 800	92
1949–50	14, 300	12, 900	90
1950–51	11, 500	10, 100	88
1951–52	9, 700	8, 500	87
1952–53	9, 800	8, 500	87
1953–54	11, 200	9, 500	85
1954–55	10, 300	8, 900	87
1955–56	10, 900	9, 600	88
1956–57	9, 700	8, 300	86
1957–58	11, 800	9, 500	80
1958–59	12, 600	10, 000	79
1959–60	10, 800	8, 700	81
1960–61	11, 400	9, 200	81
1961–62	11, 500	9, 500	83
1962–63	12, 300	9, 900	81
1963–64	11, 700	10, 000	86
1964–65	10, 900	9, 300	85
1965	10, 000	8, 500	85
1966	9, 100	8, 200	90
1967	8, 900	8, 200	92
1968	8, 800	8, 100	92
1969	7, 400	6, 700	91
1970	8, 200	7, 400	90
1971	10, 400	9, 200	88
1972	12, 600	11, 300	90

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[1] Before Jan. 1, 1947, only claims for total and permanent disability were allowable; thereafter, annuities were also granted on account of occupational disability.

[2] Fiscal years through 1964–65; calendar years beginning with 1965.

TABLE 116.—*Selected characteristics of employee disability annuities awarded and in current-payment status,[1] 1936–73*

	Awarded during year			In current-payment status at end of year [1]			
Calendar year	Number	Percent of all regular employee annuities	Average age at accrual	Number	Percent of all regular employee annuities	Average monthly amount	Amount paid in year (millions)
1937 [2]	2, 500	6	60. 3	1, 300	3	$85	$1. 5
1938	10, 500	22	60. 4	10, 400	13	75	12. 4
1939	7, 300	28	60. 3	11, 600	12	72	13. 6
1940	6, 000	27	60. 3	13, 000	12	72	14. 0
1941	5, 000	26	60. 2	13, 800	11	71	14. 3
1942	4, 000	27	60. 2	13, 300	10	70	18. 5
1943	4, 300	24	60. 1	12, 900	10	70	13. 4
1944	4, 200	23	60. 1	13, 500	9	70	13. 5
1945	4, 300	18	60. 1	13, 600	9	70	13. 8
1946	5, 000	19	60. 1	14, 100	8	70	14. 4
1947	21, 800	50	57. 1	30, 000	15	66	29. 1
1948	14, 100	43	57. 3	36, 000	17	71	35. 8
1949	13, 300	37	57. 7	40, 000	17	74	41. 2
1950	12, 300	34	58. 0	42, 800	17	75	44. 6
1951	9, 700	30	58. 0	43, 000	17	88	48. 6
1952	8, 800	28	58. 0	42, 500	16	91	53. 1
1953	9, 500	27	57. 9	42, 300	15	92	54. 1
1954	9, 400	26	58. 0	42, 200	14	92	53. 9
1955	10, 000	26	58. 1	43, 000	14	92	54. 7
1956	9, 200	25	58. 1	43, 100	13	101	57. 4
1957	9, 100	23	58. 3	42, 300	13	101	59. 6
1958	10, 000	23	58. 2	42, 400	12	102	60. 5
1959	10, 200	23	58. 4	42, 300	11	116	65. 2
1960	10, 700	22	58. 0	42, 200	11	122	72. 0
1961	9, 000	23	58. 1	41, 100	10	125	70. 2
1962	10, 300	23	59. 1	41, 900	10	127	70. 2
1963	9, 700	24	58. 2	41, 400	10	130	71. 0
1964	9, 800	26	58. 2	41, 800	10	133	73. 4
1965	8, 500	24	58. 2	40, 200	9	138	73. 2
1966	8, 200	23	57. 4	39, 300	9	146	75. 7
1967	8, 200	20	57. 2	38, 300	9	149	75. 3
1968	8, 100	21	57. 1	37, 800	9	168	83. 8
1969	6, 700	20	56. 9	36, 500	8	171	82. 4
1970	7, 400	22	57. 0	36, 100	8	199	97. 7
1971	9, 200	24	57. 4	37, 700	8	227	119. 0
1972	11, 300	30	57. 4	40, 700	9	285	146. 2
1973	11, 300	33	54. 3	43, 500	10	299	178. 2

[1] Annuitants under age 65 only.
[2] Includes data for 100 annuities awarded in 1936.

Characteristics of disability annuity awards prior to the 1946 railroad retirement amendments are somewhat different from those in subsequent years because of the different eligibility requirements in the earlier period. Average credited service for awards during most of the period was about 28 years and average age at annuity beginning date hovered around age 60. However, because the benefit formula did not change during the period, there was tendency for the average annuity to stabilize around $70.

The post-1946 characteristics of the railroad retirement disability program have been affected greatly by the liberalized disability provisions of the 1946 amendments and the periodic changes in benefit formula and taxable earnings levels. In addition, average and total amounts of annuity paid to disability annuitants under age 65 have expanded greatly with continued inflation.

Glossary of Symbols

In order to conserve word space and speed the recognition of words and phrases, many agencies of government have developed their own language of abbreviations, relying heavily upon the use of symbols usually formed by grouping the first letter of key words. Though some of the symbols may readily be recognized, many will undoubtedly cause confusion. Thus, the staff has attempted to extract some of the symbols used in this report and present them in their spelled-out form.

ABD—Assistant Bureau Director
AFDC—aid to families with dependent children
ALJ—Administrative Law Judge
APA—Administrative Procedure Act
APTD—aid to permanently and totally disabled
BDI—Bureau of Disability Insurance
BDP—Bureau of Data Processing
BHA—Bureau of Hearings and Appeals
BL—Black Lung; State agency for the blind
BOASI—Bureau of Old-Age and Survivor's Insurance
BRSI—Bureau of Retirement and Survivor's Insurance
CDB—childhood disability beneficiary
CDI—continuing disability investigation
CETA—Comprehensive Employment and Training Act
CHAMPUS—civilian health and medical programs of the uniformed services
CHAMPVA—civilian health and medical programs of the Veterans' Administration
CO—central office
CRS—Case Review Section
DAC—disabled adult children
DBP—Division of Benefit Payments
DDU—disability determination unit
DI—disability insurance
DIB—disability insurance beneficiaries
DIC—Division of Initial Claims
DIL—disability insurance letter
DIRO—disability insurance regional office
DISM—disability insurance State manual
DMIP—Division of Management Information and Planning
DO—district office
DOFA—district office finally authorized
DTS—Division of Technical Services
DWB—disabled widow beneficiary
EDP—electronic data processing
FRC—Federal Records Center
HI—hospital insurance
IGPA—Intergovernmental Personnel Act of 1970
MCS—medical consultant staff
NADE—National Association of Disability Examiners
OASDI—old-age, survivors, and disability insurance
OGC—Office of the General Counsel
PC—program center
PD—presumptive disability
PIA—primary insurance benefit amount
PW—public welfare
QA—quality assurance
QED—qualtty evaluation data
RO—regional office
RR—railroad retirement; regional representative
RSA—Rehabilitation Service Administration
RSI—retirement and survivors insurance
SA—State agency
SARIS—State agency reconsideration interview study
SMI—supplementary medical insurance
SSA—Social Security Administration
SSDI—social security disability insurance
SSI—supplemental security income
SSR—Social Security Ruling; supplemental security record
VA—Veterans' Administration
VR—vocational rehabilitation